

9585

CERTIFICATE OF DEATH

Reg. Dist. No. 302

09559

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Blanche Middle Elizabeth Last Anderson				4. DATE OF DEATH Month Aug. Day 1 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 2 1890	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George M. Johnson				14. MOTHER'S MAIDEN NAME Alice Elizabeth Buser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. O. S. Potter 735 Intervak Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemolytic anemia with splenomegaly 292.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Indefinite 5 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19 Aug. 1 , 19 59 , that I last saw the deceased alive on August 1 , 19 59 , and that death occurred at 8p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St., Hagerstown, Md. DATE SIGNED 8/3/59							
ACTUAL SIGNATURE Dr. B. B. Kneisley				M.D. 148 West Washington St., Hagerstown, Md.			
PHYSICIAN'S NAME (Type) Dr. B. B. Kneisley				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 4/59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cem.		22d. LOCATION (City, town, county, state) Washington Co Hagerstown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE AUG 6 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneisley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/58

TO HOSPITAL
may be released
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed.

1

10712

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
f. STREET ADDRESS 901 Potomac Ave.,		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucretia Middle Stine Last Athey		4. DATE OF DEATH Month 8 Day 25 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1886
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 25 Hours 19 Min. 59	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11b. KIND OF BUSINESS OR INDUSTRY home	
11c. BIRTHPLACE (State or foreign country) Willow Hill, Pa.		11d. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar S. Bock		14. MOTHER'S MAIDEN NAME Ellen Stine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Howard N. Athey		18. ADDRESS Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Occlusion 332X DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 25 59 to Aug 25 59 , that I last saw the deceased alive on Aug 25 59 , and that death occurred at 3:30 PM , from the causes and on the date stated above.		DATE SIGNED 8-26-59	
ACTUAL SIGNATURE Dr. D. J. Boyer		M.D. P-26-57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-28-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR AUG 28 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

TOTAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9586

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Kehne

09561

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. STREET ADDRESS 417 Indiana Ave.			
3. NAME OF DECEASED (Type or print) First Samuel Middle Aaron Last Beard				4. DATE OF DEATH Month Aug. Day 14, Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1885	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.		11. BIRTHPLACE (State and County) Peru Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Beard				14. MOTHER'S MAIDEN NAME Susan CARBAUGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-5272		17. INFORMANT Address Mrs Myrtle Beard 417 Indiana Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis, far advanced, active DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown, Md.		(County)	(State)	
21. I certify that I attended the deceased from 4 August, 1959 to 14 August, 1959 , that I last saw the deceased alive on 14 August, 1959 , and that death occurred at 3:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 131 W. Washington St. Hagerstown, Md. DATE SIGNED 15 Aug. 1959							
ACTUAL SIGNATURE John H. Kehne M.D.							
PHYSICIAN'S NAME (Type) John H. Kehne M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 17/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, Washington Co. State) Hagerstown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE AUG 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		1526.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chronic Disease Hospital				d. STREET ADDRESS 109 Park Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eppie		First Edna		Middle BELL		Last	
4. DATE OF DEATH August 30		Month		Day		Year 1959	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1888	
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Treas. Dept.		10b. KIND OF BUSINESS OR INDUSTRY Gov't - Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ulyses Magruder Ricketts				14. MOTHER'S MAIDEN NAME Sarah Catherine Harding.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Sister		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATOID ARTHRITIS, SEVERE, MULTIPLE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 25 YRS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition, Generalized Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 29 , 19 59 , to August 30 , 19 59 , that I last saw the deceased alive on August 29 , 19 59 , and that death occurred at 4:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1500 Pennsylvania AVE DATE SIGNED 8-30-59							
ACTUAL SIGNATURE Evaristo R. Lardizabal		M.D. 1500 Pennsylvania AVE					
PHYSICIAN'S NAME (Type) Evaristo R. Lardizabal		Hagerstown, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-1-59		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Pumphrey				ADDRESS BETHESDA, MD.		24a. REC'D BY REGISTRAR DATE SEP 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9630

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G248 9-3-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

09563

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Washington</u> <u>75X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Bonnesboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>	
c. LENGTH OF STAY IN 1b <u>4 Years</u>		d. STREET ADDRESS <u>223 South Church St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fahrney-Keedy Memorial Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>S.</u> Middle <u>Allison</u> Last <u>Benedict</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/68</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Near Mercersburg Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Benedict</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Keller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Elizabeth B. Kunz, San Mar Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>August 3, 1959</u> , to <u>Aug 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug. 26</u> , 19 <u>59</u> , and that death occurred at <u>3A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Heck</u>		ADDRESS (Street, city or town, state) <u>Waynesboro Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Heck</u>		DATE SIGNED <u>8/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro Franklin Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove</u>		ADDRESS <u>Waynesboro Pa</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 31 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Huns</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

9631

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Wilson c. LENGTH OF STAY IN 1b 1 1/2 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clearspring R.F.D. #1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Charleton d. STREET ADDRESS Big Pool R.F.D. #1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES FRANKLIN BOPPE		4. DATE OF DEATH Month August Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1944
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months 1 Days 19	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student-Farmer		10b. KIND OF BUSINESS OR INDUSTRY In school-Farming Near Big Spring, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard H. Boppe		14. MOTHER'S MAIDEN NAME Clara Burkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Richard H. Boppe		Address Big Pool, RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 835X DUE TO Exhaustion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Exhaustion DUE TO (c) Exhaustion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exhaustion INTERVAL BETWEEN ONSET AND DEATH instant			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Farm tractor upset caught beneath steering wheel	
20c. TIME OF INJURY Month, Day, Year 8-18-59 Hour 4:30 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm City or town Clearspring Wash. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. E. W. D. J. T. To Jr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) A. E. W. D. J. T. To Jr		DATE SIGNED 8/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) Near Clearspring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Legg Williamsport, Md.		24a. REC'D BY REGISTRAR DATE AUG 20 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9588

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09565

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>807 Hamilton Blv'd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul Humrichouse Byer</u>				4. DATE OF DEATH Month Day Year <u>Aug. 17 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 12, 1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical Engineer Potomac Edison Co. Hagerstown, Md.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar H. Byer</u>				14. MOTHER'S MAIDEN NAME <u>Clara Humrichouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W. #1</u>				16. SOCIAL SECURITY NO. <u>314-10-5304</u>		17. INFORMANT Address <u>Rev. Paul Byer, Wyomissing, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis</u> (c) <u>Coronary Thrombosis</u> DUE TO <u>Coronary Thrombosis</u> (c) <u>Coronary Thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. E. W. Dittus</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. E. W. Dittus</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City or town or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Goffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9589

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 N. Locust St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 232 N. Locust St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Carson		4. DATE OF DEATH Month August Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 20, 1897 9. AGE (In years last birthday) 62 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman 10b. KIND OF BUSINESS OR INDUSTRY City of Hag. 11. BIRTHPLACE (State or foreign country) Hagerstown Md. 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Walter L. Carson		14. MOTHER'S MAIDEN NAME Hannah Mc Coy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 214-09-8636 INFORMANT Mrs. Myrtle Carson Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auricular Fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1959 to Aug 20, 1959 that I last saw the deceased alive on Aug 20, 1959 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. DATE SIGNED 5-21-59			
ACTUAL SIGNATURE Paul Harrison		M.D. 318 N. Potomac St.	
PHYSICIAN'S NAME (Type) Paul Harrison, M. D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-20-59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md. 24a. REC'D BY REGISTRAR AUG 24 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

05508

CERTIFICATE OF DEATH

Washington

Maryland

Leesportown

Washington

Leesportown

215 N. 1st Street

215 N. 1st Street

Leesportown

Leesportown

Leesportown

May 20, 1997

City of Md. Leesportown Md.

Registration

Marshall No 001

Marshall No 001

215-00-8030 Mrs. Marie Carson Leesportown Md.

Yes

Leesportown Md.

Leesportown Md.

Leesportown Md.

Scott T. Marshall & Son Leesportown Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9590
CERTIFICATE OF DEATH

09567
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Albemarle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenwood 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) First JOHN Middle ALBERT Last CHEAPE		4. DATE OF DEATH Month AUGUST Day 28 Year 1959	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years lost birthday) yrs. about 78		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inventor		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Kamby, Ceylon		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Cheape		14. MOTHER'S MAIDEN NAME Kathleen Sophie Hambrough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Malvina Terrell Cheape		Address Charlottesville, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA RIGHT LOWER LOBE 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ATHEROSCLEROSIS SEVERE DUE TO (c) PULMONARY EMPHYSEMA		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL VASCULAR ACCIDENT		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 7 , 19 58 , to AUG. 28 , 19 59 , that I last saw the deceased alive on AUGUST 28 , 19 59 , and that death occurred at 6.30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George Bercu		ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE	
PHYSICIAN'S NAME (Type) DR. GEORGE BERCU		DATE SIGNED 8/28/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/29/1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Franklin Royer		24a. REC'D BY REGISTRAR SEP 1 '59	
ADDRESS Hagerstown, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

9591

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>24 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Waynesboro 75x-3</u> <u>119 C. V. Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Reno</u> Last <u>Cline</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/13/1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter, Frick Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pondsville Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Cline</u>				14. MOTHER'S MAIDEN NAME <u>Hester Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>173-03-2871</u>		17. INFORMANT <u>Mrs. Francis R. Cline, 119 C.V. Ave., Waynesboro Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory and circulatory failure.</u> 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic granulomatous leptomeningitis.</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>At least 6 weeks.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 28</u> , 19 <u>59</u> , to <u>August 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August 20</u> , 19 <u>59</u> , and that death occurred at <u>5 a.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>A. F. Abdullah</u> M.D. <u>132 N. Potomac St., Hagerstown, Md.</u> 8/24/59							
PHYSICIAN'S NAME (Type) <u>A. F. Abdullah, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Gave, Waynesboro Pa</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

CERTIFICATE OF DEATH

2521

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

REPORTED BY: _____

DATE OF REPORT: _____

Signature: _____

Official Seal: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9632

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09569

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md RFD #2		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Sharpsburg Md. RFD #2	
3. NAME OF DECEASED (Type or print) First Carrie Middle Virginia Last Crampton		4. DATE OF DEATH Month Aug. Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 5 Days 22 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Tilghmanton Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Elias Potterfield		14. MOTHER'S MAIDEN NAME Laura Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Walter S. Crampton		Address Sharpsburg Md. R. F. D. #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal hepatic cirrhosis 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sep. 1 , 19 58 to 8/19/59 , 19 , that I last saw the deceased alive on 8/18/59 , 19 , and that death occurred at 1 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 8/20/59 ACTUAL SIGNATURE Walter H. Shealy M.D. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 21-59	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf-Williams		24. REC'D BY REGISTRAR AUG 24 '59	
ADDRESS Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9592 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Dr Ditto Jr.

Reg. Dist. No.

09570

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
3. NAME OF DECEASED (Type or print) First Ottie Middle Bell Last Crilley		4. DATE OF DEATH Month Aug. Day 4 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18/1900
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hancock Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Baker		14. MOTHER'S MAIDEN NAME Mary Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no None		16. SOCIAL SECURITY NO. N^one	
17. INFORMANT Richard L. Crilley		Address 1534 Crest View Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Breast (c) Metastasis to Lung		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-2- , 19 59 , to 8-4- , 19 59 , that I last saw the deceased alive on 8-3-59 , 19 59 and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. E. Ditto		ADDRESS (Street, city or town, state) Hagerstown, Md.	
DATE SIGNED 8/4/59			
PHYSICIAN'S NAME (Type) DR F. W. LITTO			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 6/59	22c. NAME OF CEMETERY OR CREMATORY Broadfording Cem.	22d. LOCATION (City, town, or county) (State) Broadfording, Md.
23. FUNERAL DIRECTOR'S SIGNATURE And rew K. Coffman		ADDRESS Hagerstown, Md	
24a. REC'D BY REGISTRAR DATE AUG 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9593 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HUBERT COLUMBUS DAGENHART		4. DATE OF DEATH AUGUST - 16 - 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL - 21 - 18 88
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 3 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) BOONSBORO WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AARON DAGENHART		14. MOTHER'S MAIDEN NAME SARAH DUTROW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-1558	
17. INFORMANT MRS. MAUDE STAUBS HAGERSTOWN MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure arteriosclerotic heart disease (c)		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 19 59, to 8-16-, 19 59, that I last saw the deceased alive on 8-16-, 19 59, and that death occurred at 7:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Hagerstown M.D. 21 N. Main St., Boonsboro, Md 8/18/59 ACTUAL SIGNATURE Joseph Secondary PHYSICIAN'S NAME (Type) JOSEPH SECONDARI			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John D. Post		24a. REC'D BY REGISTRAR DATE AUG 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

VS. AISME(5)
5M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

9595

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09573

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland c. LENGTH OF STAY IN lb 8 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland. d. STREET ADDRESS 440 Park Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHRISTOPHER Columbus DENNIS		4. DATE OF DEATH Month Day Year AUGUST 19 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 10 1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		12. KIND OF BUSINESS OR INDUSTRY Coal mine	
13. BIRTHPLACE (State or foreign country) Montgomery County Tenn.		14. CITIZEN OF WHAT COUNTRY? USA.	
15. FATHER'S NAME Mederick Dennis		16. MOTHER'S MAIDEN NAME Grace Brodus	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		18. SOCIAL SECURITY NO. 216-22-2646	
19. INFORMANT Mrs Hilda Dennis		Address 440 Park Place	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERFORATED PEPTIC ULCER 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY CONGESTION & EDEMA. CENTRAL NERVOUS SYSTEM SYPHILIS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 13, 1959 to AUGUST 19, 1959 , that I last saw the deceased alive on AUGUST 19, 1959 , and that death occurred at 10:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE. 8/20/59 DATE SIGNED ACTUAL SIGNATURE George Bercu M.D. PHYSICIAN'S NAME (Type) DR. GEORGE BERCU. HAGERSTOWN MARYLAND.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-22-1959	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.		24a. REC'D BY REGISTRAR DATE AUG 24 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Thomas			

MEDICAL CERTIFICATION

2

091

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M

9593

CERTIFICATE OF DEATH

Washington, Maryland, U.S.A.

Christophe, Christopher, 440 Park Place

440 Park Place, Washington, D.C.

CHRISTOPHE, CHRISTOPHER, 440 Park Place

440 Park Place, Washington, D.C.

440 Park Place, Washington, D.C.

440 Park Place, Washington, D.C.

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440 Park Place, Washington, D.C.

440 Park Place, Washington, D.C.

9633

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09574

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg</u>	c. LENGTH OF STAY IN 1b <u>34 Years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Smithsburg #2</u>		d. STREET ADDRESS <u>Smithsburg #2</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lionel</u> Middle <u>S.</u> Last <u>Diehl</u>		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Operator, S. Power Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Near Smithsburg Md.</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George C. Diehl</u>	
14. MOTHER'S MAIDEN NAME <u>Carrie Johns</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-10-4937</u>		17. INFORMANT <u>Mrs. Lionel S. Diehl, Smithsburg Md., #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma toxic</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>11:20 PM</u> , 19 <u>59</u> , to <u>8:25 PM</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11:20 PM</u> , 19 <u>59</u> , and that death occurred at <u>Waynesboro, Franklin Pa.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>C. W. Lindeman</u> M.D. _____			
PHYSICIAN'S NAME (Type) <u>C. W. Lindeman</u> <u>Waynesboro, Franklin Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh's</u>	22d. LOCATION (City, town, or county) (State) <u>Smithsburg #2, Franklin Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hone</u>		ADDRESS <u>Waynesboro Pa.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 28 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hone</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AM BOM

THIS IS CERTIFICATE OF
DEATH OF
JAMES BOM
DIED AT
HOSPITAL
ON
JANUARY 10
1900
AT
AGE
OF
30
YEARS
AND
HIS
BURIAL
WAS
AT
THE
CATHOLIC
CEMETERY
IN
BALTIMORE
MARYLAND
ON
JANUARY 12
1900
AT
10
O'CLOCK
A.M.

9833

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED <i>James BOM</i>		AGE <i>30</i>		SEX <i>M</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 10 1900</i>		PLACE OF DEATH <i>Hospital</i>		CITY <i>Baltimore</i>		COUNTY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>None</i>		EDUCATION <i>None</i>	
PLACE OF BIRTH <i>Germany</i>		DATE OF BIRTH <i>Jan 10 1870</i>		PLACE OF BIRTH <i>Germany</i>		DATE OF BIRTH <i>Jan 10 1870</i>	
NAME OF FATHER <i>John BOM</i>		NAME OF MOTHER <i>Mary BOM</i>		NAME OF SPOUSE <i>None</i>		NAME OF CHILDREN <i>None</i>	
NAME OF PHYSICIAN <i>Dr. J. B. Smith</i>		NAME OF BURIAL PLACE <i>Catholic Cemetery</i>		NAME OF MINISTER <i>Rev. J. B. Smith</i>		NAME OF WITNESSES <i>None</i>	
NAME OF REGISTRAR <i>John BOM</i>		NAME OF CLERK <i>John BOM</i>		NAME OF ASSISTANT CLERK <i>John BOM</i>		NAME OF DEPUTY CLERK <i>John BOM</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9634

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G246 8-21-59 et

CERTIFICATE OF DEATH

09575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON New Windsor	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONS BORO RURAL YEARS		c. LENGTH OF STAY IN 1b BOONS BORO RURAL 06 X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAHRNEY-KEEDY MEM. HOME		d. STREET ADDRESS FAHRNEY-KEEDY MEM. HOME	
3. NAME OF DECEASED (Type or print) MARIANNA ROYER ENGLER		4. DATE OF DEATH AUG 11 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/21/1876
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JEHU ROYER		14. MOTHER'S MAIDEN NAME MARY MARGARET BOWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT MRS. H. PAUL HULL		Address NEW WINDSOR MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 2 1958 , to AUG 11 1959 , that I last saw the deceased alive on AUG 10 1959 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro Md DATE SIGNED 8/11/59			
ACTUAL SIGNATURE G. W. LeVan		M.D. Boonsboro Md	
PHYSICIAN'S NAME (Type) G. W. LeVan		BOONS BORO Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/14/59	
22c. NAME OF CEMETERY OR CREMATORY PIPE CREEK CEM		22d. LOCATION (City, town, or county) (State) CARROLL COUNTY MD	
23. FUNERAL DIRECTOR'S SIGNATURE O. Hartzlutz		ADDRESS New Windsor Md	
24a. REC'D BY REGISTRAR AUG 14 '59		24b. REGISTRAR'S SIGNATURE Orbert S. Knecht	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

REG. CODE 100

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		WHITE		MEMPHIS, TENN.	
6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
APRIL 4, 1968		4:00 PM		MEMPHIS, TENN.		SHOOTING		HOMICIDE	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF NEXT OF KIN		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF REGISTRAR	
16. CERTIFICATE OF DEATH		17. CERTIFICATE OF DEATH		18. CERTIFICATE OF DEATH		19. CERTIFICATE OF DEATH		20. CERTIFICATE OF DEATH	
21. CERTIFICATE OF DEATH		22. CERTIFICATE OF DEATH		23. CERTIFICATE OF DEATH		24. CERTIFICATE OF DEATH		25. CERTIFICATE OF DEATH	
26. CERTIFICATE OF DEATH		27. CERTIFICATE OF DEATH		28. CERTIFICATE OF DEATH		29. CERTIFICATE OF DEATH		30. CERTIFICATE OF DEATH	
31. CERTIFICATE OF DEATH		32. CERTIFICATE OF DEATH		33. CERTIFICATE OF DEATH		34. CERTIFICATE OF DEATH		35. CERTIFICATE OF DEATH	
36. CERTIFICATE OF DEATH		37. CERTIFICATE OF DEATH		38. CERTIFICATE OF DEATH		39. CERTIFICATE OF DEATH		40. CERTIFICATE OF DEATH	
41. CERTIFICATE OF DEATH		42. CERTIFICATE OF DEATH		43. CERTIFICATE OF DEATH		44. CERTIFICATE OF DEATH		45. CERTIFICATE OF DEATH	
46. CERTIFICATE OF DEATH		47. CERTIFICATE OF DEATH		48. CERTIFICATE OF DEATH		49. CERTIFICATE OF DEATH		50. CERTIFICATE OF DEATH	
51. CERTIFICATE OF DEATH		52. CERTIFICATE OF DEATH		53. CERTIFICATE OF DEATH		54. CERTIFICATE OF DEATH		55. CERTIFICATE OF DEATH	
56. CERTIFICATE OF DEATH		57. CERTIFICATE OF DEATH		58. CERTIFICATE OF DEATH		59. CERTIFICATE OF DEATH		60. CERTIFICATE OF DEATH	
61. CERTIFICATE OF DEATH		62. CERTIFICATE OF DEATH		63. CERTIFICATE OF DEATH		64. CERTIFICATE OF DEATH		65. CERTIFICATE OF DEATH	
66. CERTIFICATE OF DEATH		67. CERTIFICATE OF DEATH		68. CERTIFICATE OF DEATH		69. CERTIFICATE OF DEATH		70. CERTIFICATE OF DEATH	
71. CERTIFICATE OF DEATH		72. CERTIFICATE OF DEATH		73. CERTIFICATE OF DEATH		74. CERTIFICATE OF DEATH		75. CERTIFICATE OF DEATH	
76. CERTIFICATE OF DEATH		77. CERTIFICATE OF DEATH		78. CERTIFICATE OF DEATH		79. CERTIFICATE OF DEATH		80. CERTIFICATE OF DEATH	
81. CERTIFICATE OF DEATH		82. CERTIFICATE OF DEATH		83. CERTIFICATE OF DEATH		84. CERTIFICATE OF DEATH		85. CERTIFICATE OF DEATH	
86. CERTIFICATE OF DEATH		87. CERTIFICATE OF DEATH		88. CERTIFICATE OF DEATH		89. CERTIFICATE OF DEATH		90. CERTIFICATE OF DEATH	
91. CERTIFICATE OF DEATH		92. CERTIFICATE OF DEATH		93. CERTIFICATE OF DEATH		94. CERTIFICATE OF DEATH		95. CERTIFICATE OF DEATH	
96. CERTIFICATE OF DEATH		97. CERTIFICATE OF DEATH		98. CERTIFICATE OF DEATH		99. CERTIFICATE OF DEATH		100. CERTIFICATE OF DEATH	

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST AND PAYMENT OF A FEE. IT IS TO BE DESTROYED AFTER FIFTY YEARS.

9596

CERTIFICATE OF DEATH

09576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Comberland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carlisle</u>		<u>75X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Comm. Home</u>				d. STREET ADDRESS <u>67 West North St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>J.</u> Last <u>Failor</u>				4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/15/1871</u>		9. AGE (In years last birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Comberland Co. Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Levi Failor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mrs. Mary Ingers, State Gene. Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio-Sclerosis</u> DUE TO (c) <u>40 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of hip 1956-</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>55</u> to <u>Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>29 Aug</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. Webster</u>				ADDRESS (Street, city or town, state) <u>Greencastle</u>		DATE SIGNED <u>R. 31/1/59</u>	
PHYSICIAN'S NAME (Type) <u>Harold M. Zimmerman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Newville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Newville Comberland, Penn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>				ADDRESS <u>Greencastle, Pa</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15		CERTIFICATE OF DEATH		2553	
NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1915		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
65		Male		White	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
JANUARY 1, 1850		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
MARRIED		EDUCATION		OCCUPATION	
Yes		High School		Carpenter	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
Heart Disease		Natural		Catholic Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 15, 1915		JANUARY 15, 1915		JANUARY 15, 1915	
LOCAL HEALTH OFFICER		COUNTY HEALTH OFFICER		STATE HEALTH OFFICER	
J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 15, 1915		JANUARY 15, 1915		JANUARY 15, 1915	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9635

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09577

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u>		c. LENGTH OF STAY IN 1b <u>15 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>37 WEST MAPLE ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OMER EARL FORREST</u>		4. DATE OF DEATH Month Day Year <u>AUGUST - 22 - 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25 1886</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>1 27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLER RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STICHELL MILL</u>	
11. BIRTHPLACE (State or foreign country) <u>FRED. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB FORREST</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE WARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214 09-3035</u>	
17. INFORMANT <u>WAYNE FORREST</u>		Address <u>37 W. MAPLE ST. FUNKSTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 22, 1959</u> , to <u>Aug 22, 1959</u> , that I last saw the deceased alive on <u>Aug 22, 1959</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>217 W. Washington St.</u> <u>8/24/59</u>			
ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D.		PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 25 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MIDDLETOWN FRED. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9636

CERTIFICATE OF DEATH

Reg. Dist. No.

09578

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Wilson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Indian Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		d. STREET ADDRESS Big Pool R.F.D. #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minnie Middle B. Last Forsythe		4. DATE OF DEATH Month August Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 3 Days 8	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) St. Paul's Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jim Mills		14. MOTHER'S MAIDEN NAME Mary Kensil	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
INFORMANT Mr. Leonard Forsythe		Address Big Pool, Md. RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO General arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic heart dr. DUE TO 10 yrs (c) Parasitic thrombosis DUE TO 6 Mar PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pneumonia - lobes 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13, 1959 to Aug 13, 1959 , that I last saw the deceased alive on Aug 13, 1959 , and that death occurred at 6:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 212 W. Washington St. Hagerstown, Md. DATE SIGNED 8/14/59 ACTUAL SIGNATURE Edward W. Ditto III M.D. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Aug. 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Shantown E.U.B. Cemetery		22d. LOCATION (City, town, or county) (State) Near Big Pool, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leg Williams, Md.		24a. REC'D BY REGISTRAR AUG 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9597 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09579

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>57 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>817 Medway Road</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>817 Medway Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK</u> <u>FRATIANNI</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>6</u> <u>1959</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 29, 1888</u>		9. AGE (In years last birthday) <u>70 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Barbershop</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Danoto Fratianni</u>						14. MOTHER'S MAIDEN NAME <u>Francesca Gallicchio</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-14-5593</u>		17. INFORMANT Address <u>Francis W. Fratianni Hagerstown Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 month</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>[Signature]</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Dr. E. W. H. [Signature]</u>						DATE SIGNED <u>9/1/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/8/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Superior Funeral Home Hagerstown Md</u>						24a. REC'D BY REGISTRAR DATE <u>AUG 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9637

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09580

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Antietam		c. LENGTH OF STAY IN 1b 71 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Antietam			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence				d. STREET ADDRESS Harpers Ferry Rpad		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last GARDNER				4. DATE OF DEATH Month August Day 25 , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1888		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Silk Mill		11. BIRTHPLACE (State or foreign country) Antietam, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Gardner				14. MOTHER'S MAIDEN NAME Mary Ellen Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-3647		17. INFORMANT Mrs. Martha A. Gardner R.F.D.#1, Harpers Ferry, W.Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive Cardio Vascular Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/28/59		22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery	
22d. LOCATION (City, town, or county) (State) Samples Manor, Md.				22e. REC'D BY REGISTRAR DATE AUG 28 '59			
23. FUNERAL DIRECTOR'S SIGNATURE Ronald Cackles				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		OCCUPATION [REDACTED]		PLACE OF BIRTH [REDACTED]	
MARITAL STATUS [REDACTED]		PREVIOUS MARRIAGES [REDACTED]		DATE OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF CORONER [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9598

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09581

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 80 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION JACKSON CONV. HOME				e. STREET ADDRESS 264 S. POTOMAC ST?			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First BERTHA Middle ALICE Last GRIFFENBERG		4. DATE OF DEATH		Month AUGUST Day 6 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1871	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH KROTZER				14. MOTHER'S MAIDEN NAME NANCY JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. THERESA B. McCUNE		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enteritis						INTERVAL BETWEEN ONSET AND DEATH 45 mins.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from August 6, 1959 , to August 6, 1959 , that I last saw the deceased alive on August 6, 1959 , and that death occurred at 5:58 p. M. from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE W. J. Norman M.D. 100 Professional Arts Bldg. 8/7/59 PHYSICIAN'S NAME (Type) William T. Layman, M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/8/59		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR AUG 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

1
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. Pages 3 and 4 should be filled with the information required by the law. Pages 1 and 2 should be filled with the information required by the law. Pages 3 and 4 should be filled with the information required by the law.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9638									
CERTIFICATE OF DEATH									
Reg. Dist. No. 09582									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro Md RFD 2					c. LENGTH OF STAY IN 1b 1 yr.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION On Alternate RFD #40					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Raleigh Middle Abram Last Griffith					4. DATE OF DEATH Month Aug. Day 1 Year 1959				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22 1882		9. AGE (In years last birthday) yrs. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner RET'D		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Keedysville Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A		IF UNDER 1 YEAR Months 6 Days 9 Hours Min. 	
13. FATHER'S NAME Abram Griffith					14. MOTHER'S MAIDEN NAME Susan Wolf				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT Mrs. Mary Griffith					Address Boonsboro Md. RFD #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive heart failure DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 Days.									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 7-26-1959 to 7-31-1959 , that I last saw the deceased alive on 7-31-1959 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro Md. DATE SIGNED 8-1-59 ACTUAL SIGNATURE Joseph Secundari M.D. PHYSICIAN'S NAME (Type) Joseph Secundari, M.D. 21 N. Main St., Boonsboro, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF Aug. 3 1959									
22c. NAME OF CEMETERY OR CREMATORY Mt. Lena Cemetery									
22d. LOCATION (City, town, or county) (State) Mt. Lena Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Wilhomsport, Md									
24a. REC'D BY REGISTRAR DATE AUG 4 1959									
24b. REGISTRAR'S SIGNATURE Arthur S. Frank									

1939

DEPARTMENT OF HEALTH

Washington, D.C.

Report of the

Commissioner of Health

for the year 1938

and the

Department of Health

for the year 1938

and the

Department of Health

for the year 1938

and the

Department of Health

for the year 1938

and the

Department of Health

for the year 1938

and the

Department of Health

9599

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09583

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CO. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GREGORY Middle LEE Last GROVE		4. DATE OF DEATH Month 8 Day #31 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 27, 1957
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLYDE M. GROVE		14. MOTHER'S MAIDEN NAME SHIRLEY E. SPRENKLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CLYDE M. GROVE		Address HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 936.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suffocation by Hanging DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Caught head between boards in corn crib	
20c. TIME OF INJURY Month, Day, Year 11 8-31-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	20f. (City or town) (County) (State) Hagerstown Washington MD
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. E. W. L. T. T. J.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) A. E. W. L. T. T. J.		DATE SIGNED 9/1/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/2/59	22c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON CO., MD.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK		ADDRESS CLEAR SPRING, MD.	
24a. REC'D BY REGISTRAR DATSEP 4 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9600

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

19584

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington County</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Alleghany</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westernport</i> 0143-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington County Hospital</i>			d. STREET ADDRESS <i>511 Maryland Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Marion</i> Middle <i>Marie</i> Last <i>Suy</i>			4. DATE OF DEATH Month <i>August</i> Day <i>9</i> Year <i>1959</i>		
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 4, 1910</i>		9. AGE (In years lost birthday) <i>48</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Charles Beeman</i>			14. MOTHER'S MAIDEN NAME <i>Marion Nichol</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Eldridge Guy- Westernport, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary infarction + edema</i> <i>157x</i> DUE TO Non-bacterial endocarditis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Carcinoma of tail of pancreas e' metastasis to liver & lung</i> (c) <i>Infarctions in spleen, kidneys and brain.</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>Several weeks</i> <i>Unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Infarctions in spleen, kidneys and brain.</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August 7, 1959</i> , to <i>August 9, 1959</i> , that I last saw the deceased alive on <i>August 8, 1959</i> , and that death occurred at <i>1:55</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>A. F. Abdullah</i> M.D. <i>132 N. Potomac</i> PHYSICIAN'S NAME (Type) <i>A. F. Abdullah</i> <i>Hagerstown, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/12/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Philos Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Westernport Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. J. Boral</i>			ADDRESS <i>Westernport, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 11 '59</i>
			24b. REGISTRAR'S SIGNATURE <i>Charles S. Knaus</i>		

1880

CERTIFICATE OF DEATH

1. NAME OF DECEASED Charles Joseph		2. SEX Male		3. AGE 35	
4. PLACE OF BIRTH Boston, Mass.		5. DATE OF BIRTH Jan. 1, 1845		6. PLACE OF DEATH Boston, Mass.	
7. CAUSE OF DEATH Diphtheria		8. PERIOD OF ILLNESS 10 days		9. TIME OF DEATH 10:30 A.M.	
10. SIGNATURE OF PHYSICIAN J. W. Smith		11. SIGNATURE OF WITNESSES J. W. Smith, J. D. Jones		12. SIGNATURE OF REGISTRAR J. W. Smith	
13. NAME OF FUNERAL HOME J. W. Smith		14. NAME OF BURIAL PLACE J. W. Smith		15. NAME OF CEMETERY J. W. Smith	
16. NAME OF FUNERAL HOME J. W. Smith		17. NAME OF BURIAL PLACE J. W. Smith		18. NAME OF CEMETERY J. W. Smith	
19. NAME OF FUNERAL HOME J. W. Smith		20. NAME OF BURIAL PLACE J. W. Smith		21. NAME OF CEMETERY J. W. Smith	
22. NAME OF FUNERAL HOME J. W. Smith		23. NAME OF BURIAL PLACE J. W. Smith		24. NAME OF CEMETERY J. W. Smith	
25. NAME OF FUNERAL HOME J. W. Smith		26. NAME OF BURIAL PLACE J. W. Smith		27. NAME OF CEMETERY J. W. Smith	
28. NAME OF FUNERAL HOME J. W. Smith		29. NAME OF BURIAL PLACE J. W. Smith		30. NAME OF CEMETERY J. W. Smith	
31. NAME OF FUNERAL HOME J. W. Smith		32. NAME OF BURIAL PLACE J. W. Smith		33. NAME OF CEMETERY J. W. Smith	
34. NAME OF FUNERAL HOME J. W. Smith		35. NAME OF BURIAL PLACE J. W. Smith		36. NAME OF CEMETERY J. W. Smith	
37. NAME OF FUNERAL HOME J. W. Smith		38. NAME OF BURIAL PLACE J. W. Smith		39. NAME OF CEMETERY J. W. Smith	
40. NAME OF FUNERAL HOME J. W. Smith		41. NAME OF BURIAL PLACE J. W. Smith		42. NAME OF CEMETERY J. W. Smith	
43. NAME OF FUNERAL HOME J. W. Smith		44. NAME OF BURIAL PLACE J. W. Smith		45. NAME OF CEMETERY J. W. Smith	
46. NAME OF FUNERAL HOME J. W. Smith		47. NAME OF BURIAL PLACE J. W. Smith		48. NAME OF CEMETERY J. W. Smith	
49. NAME OF FUNERAL HOME J. W. Smith		50. NAME OF BURIAL PLACE J. W. Smith		51. NAME OF CEMETERY J. W. Smith	
52. NAME OF FUNERAL HOME J. W. Smith		53. NAME OF BURIAL PLACE J. W. Smith		54. NAME OF CEMETERY J. W. Smith	
55. NAME OF FUNERAL HOME J. W. Smith		56. NAME OF BURIAL PLACE J. W. Smith		57. NAME OF CEMETERY J. W. Smith	
58. NAME OF FUNERAL HOME J. W. Smith		59. NAME OF BURIAL PLACE J. W. Smith		60. NAME OF CEMETERY J. W. Smith	
61. NAME OF FUNERAL HOME J. W. Smith		62. NAME OF BURIAL PLACE J. W. Smith		63. NAME OF CEMETERY J. W. Smith	
64. NAME OF FUNERAL HOME J. W. Smith		65. NAME OF BURIAL PLACE J. W. Smith		66. NAME OF CEMETERY J. W. Smith	
67. NAME OF FUNERAL HOME J. W. Smith		68. NAME OF BURIAL PLACE J. W. Smith		69. NAME OF CEMETERY J. W. Smith	
70. NAME OF FUNERAL HOME J. W. Smith		71. NAME OF BURIAL PLACE J. W. Smith		72. NAME OF CEMETERY J. W. Smith	
73. NAME OF FUNERAL HOME J. W. Smith		74. NAME OF BURIAL PLACE J. W. Smith		75. NAME OF CEMETERY J. W. Smith	
76. NAME OF FUNERAL HOME J. W. Smith		77. NAME OF BURIAL PLACE J. W. Smith		78. NAME OF CEMETERY J. W. Smith	
79. NAME OF FUNERAL HOME J. W. Smith		80. NAME OF BURIAL PLACE J. W. Smith		81. NAME OF CEMETERY J. W. Smith	
82. NAME OF FUNERAL HOME J. W. Smith		83. NAME OF BURIAL PLACE J. W. Smith		84. NAME OF CEMETERY J. W. Smith	
85. NAME OF FUNERAL HOME J. W. Smith		86. NAME OF BURIAL PLACE J. W. Smith		87. NAME OF CEMETERY J. W. Smith	
88. NAME OF FUNERAL HOME J. W. Smith		89. NAME OF BURIAL PLACE J. W. Smith		90. NAME OF CEMETERY J. W. Smith	
91. NAME OF FUNERAL HOME J. W. Smith		92. NAME OF BURIAL PLACE J. W. Smith		93. NAME OF CEMETERY J. W. Smith	
94. NAME OF FUNERAL HOME J. W. Smith		95. NAME OF BURIAL PLACE J. W. Smith		96. NAME OF CEMETERY J. W. Smith	
97. NAME OF FUNERAL HOME J. W. Smith		98. NAME OF BURIAL PLACE J. W. Smith		99. NAME OF CEMETERY J. W. Smith	
100. NAME OF FUNERAL HOME J. W. Smith		101. NAME OF BURIAL PLACE J. W. Smith		102. NAME OF CEMETERY J. W. Smith	

1880

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9639

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09585

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO c. LENGTH OF STAY IN 1b 10 YEARS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 35 SOUTH MAIN ST.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BOONSBORO d. STREET ADDRESS 35 SOUTH MAIN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ESTIE ANNIE HARSHMAN		4. DATE OF DEATH AUGUST - 14. 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER - 20 - 1877
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 9 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WOLFESVILLE FRED. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEVI BRANDENBURG		14. MOTHER'S MAIDEN NAME LOUISE GROSSNICKLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. LUELLA KEPLER		Address BOONSBORO MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage from hiatus oesophagus DUE TO (c) 2 months		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1959 , to Aug 19, 1959 , that I last saw the deceased alive on Aug. 13, 1959 , and that death occurred at H.A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Levan		ADDRESS (Street, city or town, state) Boonsboro Md	
PHYSICIAN'S NAME (Type) G. W. Levan		DATE SIGNED 8/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 17 - 1959	
22c. NAME OF CEMETERY OR CREMATORY GROSSNICKLE CEMETERY		22d. LOCATION (City, town, or county) (State) NR MYERSVILLE FRED. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Bost		24a. REC'D BY REGISTRAR Aug 24 '59	
ADDRESS Boonsboro MD		24b. REGISTRAR'S SIGNATURE Clifford L. Kline	

1900-1901

9601

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATHARINE Middle MAE Last HARTMANFT				4. DATE OF DEATH Month August Day 25 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY McCauley & Cooley		11. BIRTHPLACE (State or foreign country) Fairview Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rev Saml D. Hardranft				14. MOTHER'S MAIDEN NAME Sarah Minnich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-0249		17. INFORMANT George R. Hartmanft Address 1069 Lincoln Way E			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia - acute 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 14 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from June 9, 1958 , to Aug. 25, 1959 , that I last saw the deceased alive on Aug. 25, 1959 , and that death occurred at 1:10 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. C. Hoffman M.D.				ADDRESS (Street, city or town, state) 214 N. Potomac St.		DATE SIGNED 8/25/59	
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/27/59	22c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		22d. LOCATION (City, town, or county) (State) Broadfording Wash Co Md			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE AUG 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1000

1. NAME OF DECEASED JOHN J. HENNING		2. SEX Male	
3. AGE 10 Days		4. DATE OF BIRTH 10-25-1900	
5. PLACE OF BIRTH St. Louis, Mo.		6. COUNTY St. Louis	
7. MARITAL STATUS Single		8. OCCUPATION None	
9. CAUSE OF DEATH Infantile		10. PLACE OF DEATH St. Louis, Mo.	
11. DATE OF DEATH 10-25-1900		12. TIME OF DEATH 10:00 AM	
13. SIGNATURE OF PHYSICIAN Dr. J. H. H. H.		14. SIGNATURE OF REGISTRAR Dr. J. H. H. H.	
15. SIGNATURE OF WITNESS Dr. J. H. H. H.		16. SIGNATURE OF WITNESS Dr. J. H. H. H.	
17. SIGNATURE OF WITNESS Dr. J. H. H. H.		18. SIGNATURE OF WITNESS Dr. J. H. H. H.	
19. SIGNATURE OF WITNESS Dr. J. H. H. H.		20. SIGNATURE OF WITNESS Dr. J. H. H. H.	
21. SIGNATURE OF WITNESS Dr. J. H. H. H.		22. SIGNATURE OF WITNESS Dr. J. H. H. H.	
23. SIGNATURE OF WITNESS Dr. J. H. H. H.		24. SIGNATURE OF WITNESS Dr. J. H. H. H.	
25. SIGNATURE OF WITNESS Dr. J. H. H. H.		26. SIGNATURE OF WITNESS Dr. J. H. H. H.	
27. SIGNATURE OF WITNESS Dr. J. H. H. H.		28. SIGNATURE OF WITNESS Dr. J. H. H. H.	
29. SIGNATURE OF WITNESS Dr. J. H. H. H.		30. SIGNATURE OF WITNESS Dr. J. H. H. H.	
31. SIGNATURE OF WITNESS Dr. J. H. H. H.		32. SIGNATURE OF WITNESS Dr. J. H. H. H.	
33. SIGNATURE OF WITNESS Dr. J. H. H. H.		34. SIGNATURE OF WITNESS Dr. J. H. H. H.	
35. SIGNATURE OF WITNESS Dr. J. H. H. H.		36. SIGNATURE OF WITNESS Dr. J. H. H. H.	
37. SIGNATURE OF WITNESS Dr. J. H. H. H.		38. SIGNATURE OF WITNESS Dr. J. H. H. H.	
39. SIGNATURE OF WITNESS Dr. J. H. H. H.		40. SIGNATURE OF WITNESS Dr. J. H. H. H.	
41. SIGNATURE OF WITNESS Dr. J. H. H. H.		42. SIGNATURE OF WITNESS Dr. J. H. H. H.	
43. SIGNATURE OF WITNESS Dr. J. H. H. H.		44. SIGNATURE OF WITNESS Dr. J. H. H. H.	
45. SIGNATURE OF WITNESS Dr. J. H. H. H.		46. SIGNATURE OF WITNESS Dr. J. H. H. H.	
47. SIGNATURE OF WITNESS Dr. J. H. H. H.		48. SIGNATURE OF WITNESS Dr. J. H. H. H.	
49. SIGNATURE OF WITNESS Dr. J. H. H. H.		50. SIGNATURE OF WITNESS Dr. J. H. H. H.	
51. SIGNATURE OF WITNESS Dr. J. H. H. H.		52. SIGNATURE OF WITNESS Dr. J. H. H. H.	
53. SIGNATURE OF WITNESS Dr. J. H. H. H.		54. SIGNATURE OF WITNESS Dr. J. H. H. H.	
55. SIGNATURE OF WITNESS Dr. J. H. H. H.		56. SIGNATURE OF WITNESS Dr. J. H. H. H.	
57. SIGNATURE OF WITNESS Dr. J. H. H. H.		58. SIGNATURE OF WITNESS Dr. J. H. H. H.	
59. SIGNATURE OF WITNESS Dr. J. H. H. H.		60. SIGNATURE OF WITNESS Dr. J. H. H. H.	
61. SIGNATURE OF WITNESS Dr. J. H. H. H.		62. SIGNATURE OF WITNESS Dr. J. H. H. H.	
63. SIGNATURE OF WITNESS Dr. J. H. H. H.		64. SIGNATURE OF WITNESS Dr. J. H. H. H.	
65. SIGNATURE OF WITNESS Dr. J. H. H. H.		66. SIGNATURE OF WITNESS Dr. J. H. H. H.	
67. SIGNATURE OF WITNESS Dr. J. H. H. H.		68. SIGNATURE OF WITNESS Dr. J. H. H. H.	
69. SIGNATURE OF WITNESS Dr. J. H. H. H.		70. SIGNATURE OF WITNESS Dr. J. H. H. H.	
71. SIGNATURE OF WITNESS Dr. J. H. H. H.		72. SIGNATURE OF WITNESS Dr. J. H. H. H.	
73. SIGNATURE OF WITNESS Dr. J. H. H. H.		74. SIGNATURE OF WITNESS Dr. J. H. H. H.	
75. SIGNATURE OF WITNESS Dr. J. H. H. H.		76. SIGNATURE OF WITNESS Dr. J. H. H. H.	
77. SIGNATURE OF WITNESS Dr. J. H. H. H.		78. SIGNATURE OF WITNESS Dr. J. H. H. H.	
79. SIGNATURE OF WITNESS Dr. J. H. H. H.		80. SIGNATURE OF WITNESS Dr. J. H. H. H.	
81. SIGNATURE OF WITNESS Dr. J. H. H. H.		82. SIGNATURE OF WITNESS Dr. J. H. H. H.	
83. SIGNATURE OF WITNESS Dr. J. H. H. H.		84. SIGNATURE OF WITNESS Dr. J. H. H. H.	
85. SIGNATURE OF WITNESS Dr. J. H. H. H.		86. SIGNATURE OF WITNESS Dr. J. H. H. H.	
87. SIGNATURE OF WITNESS Dr. J. H. H. H.		88. SIGNATURE OF WITNESS Dr. J. H. H. H.	
89. SIGNATURE OF WITNESS Dr. J. H. H. H.		90. SIGNATURE OF WITNESS Dr. J. H. H. H.	
91. SIGNATURE OF WITNESS Dr. J. H. H. H.		92. SIGNATURE OF WITNESS Dr. J. H. H. H.	
93. SIGNATURE OF WITNESS Dr. J. H. H. H.		94. SIGNATURE OF WITNESS Dr. J. H. H. H.	
95. SIGNATURE OF WITNESS Dr. J. H. H. H.		96. SIGNATURE OF WITNESS Dr. J. H. H. H.	
97. SIGNATURE OF WITNESS Dr. J. H. H. H.		98. SIGNATURE OF WITNESS Dr. J. H. H. H.	
99. SIGNATURE OF WITNESS Dr. J. H. H. H.		100. SIGNATURE OF WITNESS Dr. J. H. H. H.	

1

1000

9640

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahdney Keedy Memorial Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jennie Middle S. Last Hays				4. DATE OF DEATH Month 8 Day 12 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1875	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Joseph Stottlemeyer				14. MOTHER'S MAIDEN NAME Martha Hurley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Joe Hays, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured left hip DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs 3 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from July 22, 1959 , to Aug 12, 1959 , that I last saw the deceased alive on Aug 12, 1959 and that death occurred at 7:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. L. & Co.			ADDRESS (Street, city or town, state) Boonsboro Md.		DATE SIGNED 8/13/59		
PHYSICIAN'S NAME (Type) G. W. L. & Co.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8/15/1959	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Wolfsville Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.			24a. REC'D BY REGISTRAR DATE AUG 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kross		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of identifying a problem is to recognize that a problem exists. This is often done by comparing current performance with a desired state or goal. If there is a significant difference, a problem is identified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate for this purpose should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9602

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09588

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. HOSPITAL</u>				d. STREET ADDRESS <u>MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) <u>FRANKLIN T. HODGES</u>				4. DATE OF DEATH <u>AUGUST 29 - 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 1 - 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER - GOVERNMENT PRINTING OFFICE</u>		11. BIRTHPLACE (State or foreign country) <u>MONTGOMERY Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HODGES</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH WINDSOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. CLEO FLOAK KEEDYSVILLE MD.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>584X</u> DUE TO <u>Ruptured Saccular Bladder Perforation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Cholecystitis & Prostatitis</u> (c) <u>Nephrosclerosis with Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 yrs. (?)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis with Uremia</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 17</u> , 19 <u>59</u> , to <u>Aug 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 29</u> , 19 <u>59</u> , and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D.				ADDRESS (Street, city or town, state) <u>8/31/59</u>			
PHYSICIAN'S NAME (Type) <u>WALTER H. SHEALY M.D. SHARPSBURG, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEEDYSVILLE WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bart</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>			

CERTIFICATE OF DEATH

DEATH RECORD

Blank form with horizontal lines for text entry.



Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

9603

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09589

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mercersburg 75 x -3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Grant</u> Middle <u>Hoffman</u> Last		4. DATE OF DEATH <u>Aug. 12</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1884</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Twp</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Hettie Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Noble Pittman - Mercersburg, Pa.</u> Address <u>RD 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY SCLEROSIS WITH</u> XXXXXX <u>THROMBOSIS.</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 HOURS</u> <u>Thrombosis: 5 hrs.</u> <u>Sclerosis: many years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September, 1939</u> , to <u>August 12, 1959</u> , that I last saw the deceased alive on <u>August 12, 1959</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William C. Brewer</u> M.D. 359 E. Baltimore St., Greencastle, Pa. 8/13/59			
PHYSICIAN'S NAME (Type) <u>WILLIAM C. BREWER</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>St. Thomas, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle, Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 17 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MEDICAL CERTIFICATION

I

081

M

1

CERTIFICATE OF DEATH

2020

1. Name of Deceased: *John - Macdonald*

2. Sex: *Male*

3. Date of Birth: *1912*

4. Date of Death: *1912*

5. Place of Birth: *Scotland*

6. Place of Death: *Great Hall*

7. Cause of Death: *Heart Failure*

8. Duration of Illness: *10 days*

9. Name of Physician: *Dr. J. H. Jones*

10. Name of Undertaker: *John - Macdonald*

11. Name of Burial Place: *St. James Church*

12. Name of Minister: *Rev. J. H. Jones*

13. Name of Registrar: *John - Macdonald*

14. Name of Coroner: *John - Macdonald*

15. Name of Jury: *John - Macdonald*

16. Name of Witnesses: *John - Macdonald*

17. Name of Witnesses: *John - Macdonald*

18. Name of Witnesses: *John - Macdonald*

19. Name of Witnesses: *John - Macdonald*

20. Name of Witnesses: *John - Macdonald*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9641 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09590

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Fairplay, Md.		c. LENGTH OF STAY IN 1b 4 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Boonsboro RFD #1 Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Frank Last Howard		4. DATE OF DEATH Month Aug. Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1 1929
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 0 Days 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Raymond C. Howard		14. MOTHER'S MAIDEN NAME Edna Nichels	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 220-26-0758	
17. INFORMANT Mr. Raymond Howard		Address Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Piercing Heart DUE TO (c) Hemorrhage in th PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound of chest	
20c. TIME OF INJURY Month, Day, Year Hour 6 a.m. 8-27-59 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Sharpsburg Washington Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE A. SW Outen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) TRENDLETT		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Wolf Williamsport Md		24a. REC'D BY REGISTRAR DATE SEP 1 '59	
		24b. REGISTRAR'S SIGNATURE William S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9604

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09591

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 45 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lula Middle Agnes Last Itneyer		4. DATE OF DEATH Month Aug. Day 16, Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1890
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY clothing store	
11. BIRTHPLACE (State or foreign country) Union Bridge, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William P. Young		14. MOTHER'S MAIDEN NAME Carrie Stahl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-12-7579	
17. INFORMANT Roy E. Itneyer, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/17, 1959 to 8/16, 1959 , that I last saw the deceased alive on 8/15, 1959 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert V. H. Campbell M.D.		ADDRESS (Street, city or town, state) 145 W Washington St Hagerstown Md	
DATE SIGNED 8/17/59			
PHYSICIAN'S NAME (Type) Robert V. H. Campbell		Hagerstown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-19-59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

3864

Age

Sex

Washington

1. Cause

2. Date

3. Time

4. Place

5. Hospital

6. Age

7. Sex

8. Race

9. Birth

10. Date

11. Time

12. Place

13. Cause

14. Date

15. Time

16. Place

17. Cause

18. Date

19. Time

20. Place

21. Cause

22. Date

23. Time

24. Place

25. Cause

26. Date

27. Time

28. Place

29. Cause

30. Date

31. Time

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

9605

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

95592

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 729 Orchard Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH PARKER JACKSON		4. DATE OF DEATH Month August Day 21 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1923
9. AGE (In years last birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	11. BIRTHPLACE (State or foreign country) Birmingham, Ala.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas S. Jackson	
14. MOTHER'S MAIDEN NAME Nell Mogridge		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes W.W.II	
16. SOCIAL SECURITY NO. 405-18-5903		17. INFORMANT Mrs. Nell Jackson Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary sclerosis (c) ?		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from not seen in life , 19 44 , that I last saw the deceased alive on 44 , 19 44 , and that death occurred at 44 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard T. Binford M.D.		ADDRESS (Street, city or town, state) 1135 Potomac Ave	
PHYSICIAN'S NAME (Type) Richard T. Binford		DATE SIGNED 21 Aug 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/1959	
22c. NAME OF CEMETERY OR CREMATORY Zachary Taylor Cem.		22d. LOCATION (City, town, or county) (State) Louisville Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Suter-Rouzer		24a. REC'D BY REGISTRAR AUG 24 59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9642

CERTIFICATE OF DEATH

09593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg Md RFD		c. LENGTH OF STAY IN 1b 87 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Antietam Furnace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Jamison Jr. Last Jamison Jr.		4. DATE OF DEATH Month Aug. Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21-1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Antietam Furnace Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME James Jamison Sr.		14. MOTHER'S MAIDEN NAME Mary Crampton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT George L. Jamison		18. ADDRESS Antietam Furnace Sharpsburg Md RFD#1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis. DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic benign prostatic hypertrophy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1 19 58 to Aug. 31 19 59 , that I last saw the deceased alive on Aug. 28 59 and that death occurred at 8 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 8/31/59			
ACTUAL SIGNATURE Walter H. Shealy		M.D. Walter H. Shealy M. D.	
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		22b. DATE THEREOF Sept. 1-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Lewis		24a. REC'D BY REGISTRAR SEP 1 '59	
24b. REGISTRAR'S SIGNATURE Williamport		24c. REGISTRAR'S SIGNATURE Williamport	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A13 (4)
15M 9/55

9606

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

09594

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 West Irvin Ave		d. STREET ADDRESS 209 West Irvin Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last OMER THOMAS KAYLOR Sr		4. DATE OF DEATH Month Day Year August 27 1959 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney at Law		10b. KIND OF BUSINESS OR INDUSTRY Lawyer	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas M Kaylor		14. MOTHER'S MAIDEN NAME Orbannah Fahrney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 217-12-2915	
17. INFORMANT Omer T. Kaylor Jr		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Indefinite		INTERVAL BETWEEN ONSET AND DEATH 20 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 1959 to death July 26, 1959 , that I last saw the deceased alive on July 26, 1959 , and that death occurred at 6:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. Hagerstown, Md. DATE SIGNED 8-28-59			
ACTUAL SIGNATURE Robert F. Keadle M.D.		DATE SEP 1 '59	
PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/30/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md. Wash Co
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. REC'D BY REGISTRAR SEP 1 '59	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE William S. Keadle	

CERTIFICATE OF DEATH

0000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Shot - Gun		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH January 5, 1933		11. TIME OF BIRTH 10:00 AM		12. PLACE OF BIRTH Jackson, Mississippi	
13. NAME OF FATHER James Earl Ray		14. NAME OF MOTHER Maureen Ray		15. NAME OF SPOUSE None	
16. NAME OF NEXT OF KIN None		17. NAME OF PHYSICIAN None		18. NAME OF FUNERAL HOME None	
19. NAME OF BURIAL PLACE None		20. NAME OF CEMETERY None		21. NAME OF INTERVIEWER None	
22. NAME OF WITNESS None		23. NAME OF SIGNER None		24. NAME OF OFFICIAL None	
25. NAME OF COUNTY None		26. NAME OF STATE None		27. NAME OF DISTRICT None	
28. NAME OF CITY None		29. NAME OF ZIP CODE None		30. NAME OF PHONE None	
31. NAME OF ADDRESS None		32. NAME OF CITY None		33. NAME OF STATE None	
34. NAME OF ZIP CODE None		35. NAME OF PHONE None		36. NAME OF ADDRESS None	
37. NAME OF CITY None		38. NAME OF STATE None		39. NAME OF DISTRICT None	
40. NAME OF COUNTY None		41. NAME OF ZIP CODE None		42. NAME OF PHONE None	
43. NAME OF ADDRESS None		44. NAME OF CITY None		45. NAME OF STATE None	
46. NAME OF ZIP CODE None		47. NAME OF PHONE None		48. NAME OF ADDRESS None	
49. NAME OF CITY None		50. NAME OF STATE None		51. NAME OF DISTRICT None	
52. NAME OF COUNTY None		53. NAME OF ZIP CODE None		54. NAME OF PHONE None	
55. NAME OF ADDRESS None		56. NAME OF CITY None		57. NAME OF STATE None	
58. NAME OF ZIP CODE None		59. NAME OF PHONE None		60. NAME OF ADDRESS None	
61. NAME OF CITY None		62. NAME OF STATE None		63. NAME OF DISTRICT None	
64. NAME OF COUNTY None		65. NAME OF ZIP CODE None		66. NAME OF PHONE None	
67. NAME OF ADDRESS None		68. NAME OF CITY None		69. NAME OF STATE None	
70. NAME OF ZIP CODE None		71. NAME OF PHONE None		72. NAME OF ADDRESS None	
73. NAME OF CITY None		74. NAME OF STATE None		75. NAME OF DISTRICT None	
76. NAME OF COUNTY None		77. NAME OF ZIP CODE None		78. NAME OF PHONE None	
79. NAME OF ADDRESS None		80. NAME OF CITY None		81. NAME OF STATE None	
82. NAME OF ZIP CODE None		83. NAME OF PHONE None		84. NAME OF ADDRESS None	
85. NAME OF CITY None		86. NAME OF STATE None		87. NAME OF DISTRICT None	
88. NAME OF COUNTY None		89. NAME OF ZIP CODE None		90. NAME OF PHONE None	
91. NAME OF ADDRESS None		92. NAME OF CITY None		93. NAME OF STATE None	
94. NAME OF ZIP CODE None		95. NAME OF PHONE None		96. NAME OF ADDRESS None	
97. NAME OF CITY None		98. NAME OF STATE None		99. NAME OF DISTRICT None	
100. NAME OF COUNTY None		101. NAME OF ZIP CODE None		102. NAME OF PHONE None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09595

9643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg rural		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle E. Last Kendall		4. DATE OF DEATH Month August Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 3, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Toms		14. MOTHER'S MAIDEN NAME Clara Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-05-6770	
17. INFORMANT Lester W. Kendall		Address Smithsburg RD1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 5 yrs.			INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-30-54 , 19____, to 8-13-59 , 19____, that I last saw the deceased alive on 8-3-59 , 19____, and that death occurred at 10:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 8-15-59			
ACTUAL SIGNATURE Charles E. Hess		M.D. Smithsburg, Md.	
PHYSICIAN'S NAME (Type) Charles E. Hess			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-16-59	22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	22d. LOCATION (City, town, or county) (State) Smithsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR AUG 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

0843

CERTIFICATE OF DEATH

Washington, D.C. 20540

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Signature of physician: [illegible]

6. Signature of registrar: [illegible]

7. Date of registration: [illegible]

8. Place of registration: [illegible]

9. Name of registrar: [illegible]

10. Signature of registrar: [illegible]

11. Date of registration: [illegible]

12. Place of registration: [illegible]

13. Name of registrar: [illegible]

14. Signature of registrar: [illegible]

15. Date of registration: [illegible]

16. Place of registration: [illegible]

17. Name of registrar: [illegible]

18. Signature of registrar: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

9607

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09598

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN MD</u> c. LENGTH OF STAY IN 1b <u>15 MINUTES</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>133 ELM ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN LUTHER - KINDALL</u>		4. DATE OF DEATH Month Day Year <u>AUGUST - 17 - 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 5 - 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>6 12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>TREGO WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH KINDALL</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE KINDALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>220-09-9164</u>	
17. INFORMANT <u>M.T. ELLER</u>		Address <u>110 ELM ST. HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Infarction</u> DUE TO (c) <u>Arterio Sclerosis - Gen</u>			INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>2 hrs.</u> <u>90'</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Aug 17</u> , 19 <u>59</u> , to <u>Aug 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>59</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 E. Antietam</u> DATE SIGNED <u>8/18/59</u> ACTUAL SIGNATURE <u>Louis G. Graff</u> M.D. PHYSICIAN'S NAME (Type) <u>Louis G. GRAFF, M.D. HAGERSTOWN MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 20, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Best</u>		ADDRESS <u>BOONSBORO MD.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9644 Items 1,9 FilmG246 8-17-59 et
CERTIFICATE OF DEATH

09597
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 17 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home Route # 2 Black Rock Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES E KLINE		4. DATE OF DEATH Month Day Year August 7 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1875
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own General farm	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Kline		14. MOTHER'S MAIDEN NAME Susan Dubel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Mrs. Ada Kline, Hagerstown, Md. Rt. # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema		INTERVAL BETWEEN ONSET AND DEATH 2 Hrs. 8 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-27, 1954, to 8-7, 1959, that I last saw the deceased alive on 7-24, 1959, and that death occurred at 1:45 P.M. from the causes and on the date stated above. Charles F. Hess M.D. Smithsburg, Md. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles F. Hess M.D. Smithsburg, Md.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Mark's Lutheran		22d. LOCATION (City, town, or county) (State) Wolfsville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		24a. REC'D BY REGISTRAR DATE AUG 13 '59	
24b. REGISTRAR'S SIGNATURE			

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
15M 9/55

9608

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 1440 GEORGE ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SHERMAN Last KLINE		4. DATE OF DEATH Month AUGUST Day 16 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1908
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER		10b. KIND OF BUSINESS OR INDUSTRY HOUSE PAINTING	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LUKE C. KLINE		14. MOTHER'S MAIDEN NAME ANNIE M. BOWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-10-3283	
17. INFORMANT MRS. MINNIE KLINE		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150x Concomitant Aspiration of DUE TO asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 12, 1959 , to 16 Aug, 1959 , that I last saw the deceased alive on 16 Aug, 1959 , and that death occurred at 12:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 N. PETERMAN ST. DATE SIGNED 140			
ACTUAL SIGNATURE DR. HOWARD N. WEEKS M.D.			
PHYSICIAN'S NAME (Type) DR. HOWARD N. WEEKS HAGERSTOWN MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/18/59	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Thomas			

10-25-01

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9645

CERTIFICATE OF DEATH

09599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR WILLIAMSPORT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Boonsboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMEROOD REFORMED CHURCH HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GEORGIANNA</u> First Middle Last <u>KNODE</u>			4. DATE OF DEATH <u>AUGUST 15</u> 19 <u>59</u> Month Day Year				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 17 1889</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>28</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Boonsboro WASH. Co. MD. U.S.A.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>WILLIAM E. KNODE</u>				
14. MOTHER'S MAIDEN NAME <u>GEORGIANNA SMITH</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>LEON MORGAN Boonsboro MD. R. 1</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>2 hrs</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/27</u> 19 <u>59</u> , to <u>8/27</u> 19 <u>59</u> , that I last saw the deceased alive on <u>8/27</u> 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John S. Hart</u> M.D.				ADDRESS (Street, city or town, state) <u>1195 Antietam</u> DATE SIGNED <u>8/27/59</u>			
PHYSICIAN'S NAME (Type) <u>John S. Hart</u>				HAYNTON MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 18 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u> ADDRESS <u>Boonsboro MD.</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. HOWARD WEEKS
136 N. POTOMAC ST.
108

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9646

CERTIFICATE OF DEATH

Reg. Dist. No.

99600
382

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Pike</u> c. LENGTH OF STAY IN 1b <u>34 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Virginia Ave Extd</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Pike, R #2</u> d. STREET ADDRESS <u>Virginia Ave Extd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Harriet</u> Middle <u>Elizabeth</u> Last <u>Landis</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>17</u> Year <u>19 59</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 8-1882</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Church Sect'y</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State, or foreign country) <u>Berkley Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Landis</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Ripple</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Dr. Robert Liskey, Wmspt. Pike</u> Address <u>Virginia Ave Extd</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2 Dec</u> <u>1952</u> to <u>17 Aug</u> <u>1959</u> , that I last saw the deceased alive on <u>17 Aug</u> <u>1959</u> , and that death occurred at <u>6:45 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1135 POTOMAC AVE</u> <u>Washington Co</u> DATE SIGNED <u>18 Aug '59</u>									
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.				PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD</u> <u>HAGERSTOWN, MARYLAND</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Co</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2846

NAME OF DECEASED William A. Jones		SEX Male	
DATE OF BIRTH January 15, 1900		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		MARITAL STATUS Single	
PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Heart Disease	
DATE OF DEATH March 10, 1950		TIME OF DEATH 10:30 AM	
SIGNATURE OF DECEASED (Blank)		SIGNATURE OF WITNESS (Blank)	
SIGNATURE OF PHYSICIAN (Blank)		SIGNATURE OF CORONER (Blank)	
SIGNATURE OF REGISTRAR (Blank)		SIGNATURE OF CLERK (Blank)	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md., and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9609 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greencastle</u>	
c. LENGTH OF STAY IN 1b <u>14 hrs.</u>		d. STREET ADDRESS <u>Route #3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Raymond Leshner</u>		4. DATE OF DEATH Month Day Year <u>August 21 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/28/1910</u>
9. AGE in years (last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aircraft</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin F. Leshner</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-14-7581</u>	
17. INFORMANT <u>Mrs. Elizabeth Leshner, Greencastle, Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic heart disease, Chronic</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>35 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/1</u> , 19 <u>59</u> , to <u>8/21/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/21/59</u> , 19 <u>59</u> , and that death occurred at <u>Greencastle, Pa</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8/22/59</u>			
ACTUAL SIGNATURE <u>W.C. Brewer</u> M.D.		PHYSICIAN'S NAME (Type) <u>W.C. Brewer</u> <u>Greencastle, Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Franklin Co. Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald M. Zimmerman, Greencastle, Pa</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

CERTIFICATE OF DEATH

PLACE OF BIRTH
DATE OF BIRTH
SEX
MARRIAGE
EDUCATION
OCCUPATION
RELIGION
RACE
COLOR
HEIGHT
WEIGHT
HAIR
EYES
SKIN
BLOOD
TOOTH
FINGER
TONGUE
THROAT
LUNGS
LIVER
STOMACH
INTESTINES
BLADDER
RECTUM
VAGINA
PENIS
TESTES
PROSTATE
SPLEEN
PANCREAS
GALLBLADDER
BILIARY DUCTS
URINARY DUCTS
KIDNEYS
ADRENAL GLANDS
THYROID GLAND
PARATHYROID GLANDS
PITUITARY GLAND
HYPOTHYROID GLAND
THYMUS GLAND
TESTES
PROSTATE
SPLEEN
PANCREAS
GALLBLADDER
BILIARY DUCTS
URINARY DUTS
KIDNEYS
ADRENAL GLANDS
THYROID GLAND
PARATHYROID GLANDS
PITUITARY GLAND
HYPOTHYROID GLAND
THYMUS GLAND

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9610

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09602

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4 Mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Conv. Home				d. STREET ADDRESS 134 W. Washington St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GRACE Middle ROUSKULP Last LEWIS				4. DATE OF DEATH Month August Day 4 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27 1877	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Saml Edw Rouskulp				14. MOTHER'S MAIDEN NAME Sarah Ellen Brill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Helen Murray 320 So Mulberry St Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive-arteriosclerotic heart disease (c) uncertain				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - 21 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/22, 1942 to 8/4, 1959 , that I last saw the deceased alive on 8/4, 1959 , and that death occurred at 8:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 134 W. Washington, Hagerstown, Md. DATE SIGNED 8/5/59							
ACTUAL SIGNATURE John H. Hornbaker				M.D. 134 W. Washington, Hagerstown, Md.			
PHYSICIAN'S NAME (Type) John H. Hornbaker							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE AUG 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hume			

MEDICAL CERTIFICATION

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9647

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	c. LENGTH OF STAY IN 1b 16 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Route 1	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Wilber First Holland Middle Lewis Last		4. DATE OF DEATH August Month 10 Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1887
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Samples Manor Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jerome T. Lewis		14. MOTHER'S MAIDEN NAME Nannie V. Winks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-14-8686	
INFORMANT Mrs. Anna B. Lewis Address Hag. Rt. 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 years (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1-39 19 to 8-10- 1959 that I last saw the deceased alive on 8-7-59 19 and that death occurred at 7:10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 215 W. Washington St DATE SIGNED 8/14/59			
ACTUAL SIGNATURE A. E. W. Ditto Jr.		M.D. 215 W. Washington St	
PHYSICIAN'S NAME (Type) Edward W. Ditto Jr.		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-13-59	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE AUG 14 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

0647

CONTINUATION OF DEATH

Washington
10 years
Lagerstrom
Lagerstrom

about 1

Wilder
Hollins
Lewin
Lewin

White
Feb. 28, 1887

Owner
Farm
Barnes

Thomas T. Lewis
Thomas T. Lewis

215-1A-6080-10 Mrs. E. Lewis

W. W. Washington

Washington

Washington

Washington

Washington

Washington

9611

Item 5 Film G246 8-21-59 et

CERTIFICATE OF DEATH

09604

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 45yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lurty Middle (None) Last Maack				4. DATE OF DEATH Month Aug Day 14 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 20 1888	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY City Hall		11. BIRTHPLACE (State or foreign country) Zenda, Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-8213		17. INFORMANT Address Mrs. Ella Maack 410 Sumans Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis primary in Stomach. DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease.							INTERVAL BETWEEN ONSET AND DEATH Months.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 22, 1959 to August 14, 1959 , that I last saw the deceased alive on August 14, 1959 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.A. Bell		M.D. 119 N. Potomac Street		DATE SIGNED 8-17-59			
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		Hagerstown, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-17-1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John R Watson Hagerstown Md.				24a. REC'D BY REGISTRAR DATE AUG 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9612

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09605

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 Summit Ave.		d. STREET ADDRESS 202 Summit Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AGNES Middle IOLA Last MARTIN		4. DATE OF DEATH Month August Day 31 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1906
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office work		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard F. Stickler		14. MOTHER'S MAIDEN NAME Susie Crunkleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-5394	
17. INFORMANT Mr. M. F. Martin		Address 202 Summit Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-6-57 , 19 57 , to 8-31-59 , 19 59 , that I last saw the deceased alive on Aug 31 , 19 59 , and that death occurred at 10:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. DATE SIGNED 9-1-59			
ACTUAL SIGNATURE Paul Harrison M.D.			
PHYSICIAN'S NAME (Type) Paul Harrison, M. D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/3/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE SEP 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Frazier			

Wm. G. Hunt C-Plus

42800

0018

1

CERTIFICATE OF DEATH

See Note 10

<p>1. NAME OF DECEASED Howard A. Davidson</p>		<p>2. SEX Male</p>		<p>3. AGE 30</p>	
<p>4. PLACE OF BIRTH Baltimore, Md.</p>		<p>5. OCCUPATION Student</p>		<p>6. MARITAL STATUS Single</p>	
<p>7. DATE OF DEATH April 1, 1934</p>		<p>8. TIME OF DEATH 10:30 AM</p>		<p>9. PLACE OF DEATH Home, 302 South Ave., Baltimore, Md.</p>	
<p>10. CAUSE OF DEATH Heart Disease</p>		<p>11. MANNER OF DEATH Natural</p>		<p>12. SIGNATURE OF PHYSICIAN Dr. J. H. Smith</p>	
<p>13. SIGNATURE OF REGISTRAR John Doe</p>		<p>14. SIGNATURE OF WITNESS John Doe</p>		<p>15. SIGNATURE OF DECEASED Howard A. Davidson</p>	

RECEIVED BY THE BALTIMORE CITY HEALTH DEPARTMENT
 APR 1 1934
 BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9613

CERTIFICATE OF DEATH

09606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 60YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN			
d. STREET ADDRESS '16 S. MULBERRY ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HIRAM Middle MAURICE Last McKINSEY				4. DATE OF DEATH Month AUGUST Day 21 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/9/1892	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOULDER				10b. KIND OF BUSINESS OR INDUSTRY SAND BLAST MACHINE CORP.			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HIRAM McKINSEY				14. MOTHER'S MAIDEN NAME NETTIE WARBLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-09-6047			
17. INFORMANT MISS LOUISE McKINSEY				Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cerebral Thrombosis DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Marked generalized arteriosclerosis DUE TO years. (c) 1 day. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Myocardial Infarction, Recent leg amputations							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 20 June , 19 57 , to 20 Aug. , 19 59 , that I last saw the deceased alive on 20 Aug. , 19 59 , and that death occurred at 2A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1135 POTOMAC AVENUE DATE SIGNED 21 AUGUST 1959 ACTUAL SIGNATURE Richard T. Binford M.D. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D. HAGERSTOWN, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/23/59		22c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEM.		22d. LOCATION (City, town, or county) (State) SMITHSBURG MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Harwood, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE AUG 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

2010

1. NAME OF DECEASED JAMES C. BROWN		2. SEX MALE	
3. DATE OF BIRTH JANUARY 1, 1910		4. PLACE OF BIRTH BALTIMORE, MARYLAND	
5. DATE OF DEATH JANUARY 1, 1910		6. PLACE OF DEATH BALTIMORE, MARYLAND	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH HEART DISEASE	
9. PLACE OF INTERMENT BALTIMORE, MARYLAND		10. NAME OF FUNERAL HOME JAMES C. BROWN	
11. SIGNATURE OF DECEASED JAMES C. BROWN		12. SIGNATURE OF WITNESSES JAMES C. BROWN	
13. SIGNATURE OF DECEASED JAMES C. BROWN		14. SIGNATURE OF WITNESSES JAMES C. BROWN	
15. SIGNATURE OF DECEASED JAMES C. BROWN		16. SIGNATURE OF WITNESSES JAMES C. BROWN	
17. SIGNATURE OF DECEASED JAMES C. BROWN		18. SIGNATURE OF WITNESSES JAMES C. BROWN	
19. SIGNATURE OF DECEASED JAMES C. BROWN		20. SIGNATURE OF WITNESSES JAMES C. BROWN	
21. SIGNATURE OF DECEASED JAMES C. BROWN		22. SIGNATURE OF WITNESSES JAMES C. BROWN	
23. SIGNATURE OF DECEASED JAMES C. BROWN		24. SIGNATURE OF WITNESSES JAMES C. BROWN	
25. SIGNATURE OF DECEASED JAMES C. BROWN		26. SIGNATURE OF WITNESSES JAMES C. BROWN	
27. SIGNATURE OF DECEASED JAMES C. BROWN		28. SIGNATURE OF WITNESSES JAMES C. BROWN	
29. SIGNATURE OF DECEASED JAMES C. BROWN		30. SIGNATURE OF WITNESSES JAMES C. BROWN	
31. SIGNATURE OF DECEASED JAMES C. BROWN		32. SIGNATURE OF WITNESSES JAMES C. BROWN	
33. SIGNATURE OF DECEASED JAMES C. BROWN		34. SIGNATURE OF WITNESSES JAMES C. BROWN	
35. SIGNATURE OF DECEASED JAMES C. BROWN		36. SIGNATURE OF WITNESSES JAMES C. BROWN	
37. SIGNATURE OF DECEASED JAMES C. BROWN		38. SIGNATURE OF WITNESSES JAMES C. BROWN	
39. SIGNATURE OF DECEASED JAMES C. BROWN		40. SIGNATURE OF WITNESSES JAMES C. BROWN	
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43. SIGNATURE OF DECEASED JAMES C. BROWN		44. SIGNATURE OF WITNESSES JAMES C. BROWN	
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49. SIGNATURE OF DECEASED JAMES C. BROWN		50. SIGNATURE OF WITNESSES JAMES C. BROWN	
51. SIGNATURE OF DECEASED JAMES C. BROWN		52. SIGNATURE OF WITNESSES JAMES C. BROWN	
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57. SIGNATURE OF DECEASED JAMES C. BROWN		58. SIGNATURE OF WITNESSES JAMES C. BROWN	
59. SIGNATURE OF DECEASED JAMES C. BROWN		60. SIGNATURE OF WITNESSES JAMES C. BROWN	
61. SIGNATURE OF DECEASED JAMES C. BROWN		62. SIGNATURE OF WITNESSES JAMES C. BROWN	
63. SIGNATURE OF DECEASED JAMES C. BROWN		64. SIGNATURE OF WITNESSES JAMES C. BROWN	
65. SIGNATURE OF DECEASED JAMES C. BROWN		66. SIGNATURE OF WITNESSES JAMES C. BROWN	
67. SIGNATURE OF DECEASED JAMES C. BROWN		68. SIGNATURE OF WITNESSES JAMES C. BROWN	
69. SIGNATURE OF DECEASED JAMES C. BROWN		70. SIGNATURE OF WITNESSES JAMES C. BROWN	
71. SIGNATURE OF DECEASED JAMES C. BROWN		72. SIGNATURE OF WITNESSES JAMES C. BROWN	
73. SIGNATURE OF DECEASED JAMES C. BROWN		74. SIGNATURE OF WITNESSES JAMES C. BROWN	
75. SIGNATURE OF DECEASED JAMES C. BROWN		76. SIGNATURE OF WITNESSES JAMES C. BROWN	
77. SIGNATURE OF DECEASED JAMES C. BROWN		78. SIGNATURE OF WITNESSES JAMES C. BROWN	
79. SIGNATURE OF DECEASED JAMES C. BROWN		80. SIGNATURE OF WITNESSES JAMES C. BROWN	
81. SIGNATURE OF DECEASED JAMES C. BROWN		82. SIGNATURE OF WITNESSES JAMES C. BROWN	
83. SIGNATURE OF DECEASED JAMES C. BROWN		84. SIGNATURE OF WITNESSES JAMES C. BROWN	
85. SIGNATURE OF DECEASED JAMES C. BROWN		86. SIGNATURE OF WITNESSES JAMES C. BROWN	
87. SIGNATURE OF DECEASED JAMES C. BROWN		88. SIGNATURE OF WITNESSES JAMES C. BROWN	
89. SIGNATURE OF DECEASED JAMES C. BROWN		90. SIGNATURE OF WITNESSES JAMES C. BROWN	
91. SIGNATURE OF DECEASED JAMES C. BROWN		92. SIGNATURE OF WITNESSES JAMES C. BROWN	
93. SIGNATURE OF DECEASED JAMES C. BROWN		94. SIGNATURE OF WITNESSES JAMES C. BROWN	
95. SIGNATURE OF DECEASED JAMES C. BROWN		96. SIGNATURE OF WITNESSES JAMES C. BROWN	
97. SIGNATURE OF DECEASED JAMES C. BROWN		98. SIGNATURE OF WITNESSES JAMES C. BROWN	
99. SIGNATURE OF DECEASED JAMES C. BROWN		100. SIGNATURE OF WITNESSES JAMES C. BROWN	

9614

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. STREET ADDRESS 537 West Church St			
3. NAME OF DECEASED (Type or print) First Middle Last HELEN REBECCA McNAMEE				4. DATE OF DEATH Month Day Year August 21 1959 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16 1894		9. AGE (In years last birthday) yrs. 65	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry G. Nail				14. MOTHER'S MAIDEN NAME Betty E. Golden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unable to Locate		17. INFORMANT Address Mrs Mildred Benchoff Cascade Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c) Cardiac decompensation							INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 6 , 19 59 , to Aug 21 , 19 59 , that I last saw the deceased alive on Aug 20 , 19 59 , and that death occurred at 8:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 212 W. Washington St Hagerstown, Md DATE SIGNED 8/21/59 ACTUAL SIGNATURE Edward W. Dittmann PHYSICIAN'S NAME (Type) Edward W. Dittmann Hagerstown, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE AUG 25 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9615

CERTIFICATE OF DEATH

09608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 30 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last MILLS		4. DATE OF DEATH Month AUGUST Day 5 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1892
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW J. MILLS		14. MOTHER'S MAIDEN NAME FANNIE POFFENBERGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-8522	
17. INFORMANT MRS. MARY T. MILLS		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). TOXEMIA 570.5 DUE TO Idiopathic Intestinal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 5, 1959 to August 5, 1959 , that I last saw the deceased alive on August 5, 1959 , and that death occurred at 3:40 p.m. , from the cause and on the date stated above. ADDRESS (Street, city or town, state) 135 No Pot. St. DATE SIGNED 8-6-59			
ACTUAL SIGNATURE D. J. BOYER M.D.		PHYSICIAN'S NAME (Type) D. J. BOYER	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/7/59	22c. NAME OF CEMETERY OR CREMATORY MT. VIEW CEM.	22d. LOCATION (City, town, or county) (State) SHARPSBURG MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9648

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Jefferson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD. Hagerstown, Md.		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		d. STREET ADDRESS Shepherdstown 85x-3	
3. NAME OF DECEASED (Type or print) Fannie Bowly Morgan		4. DATE OF DEATH Month August Day 1st Year 1959.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20th 1893.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) RFD. Shepherdstown		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Augustine Charles Morgan (dec)		14. MOTHER'S MAIDEN NAME Frances Russell Bowly, (dec)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Augusta Phillips (Sister)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Cardiac Failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hem. DUE TO (c) 3 days 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1959 to Aug 1, 1959 , that I last saw the deceased alive on July 31, 1959 , and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Box 206 Clear Spring Md. DATE SIGNED 8/4/59			
ACTUAL SIGNATURE David R. Brewer M.D.		PHYSICIAN'S NAME (Type) David R. Brewer	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5th '59.	
22c. NAME OF CEMETERY OR CREMATORY Elmwood		22d. LOCATION (City, town, or county) (State) Shepherdstown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Melvin T. Strider, Charleston, W. Va.		24a. REC'D BY REGISTRAR DATE AUG 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

(Dr. David Brewer, Clear Spring, Md.)

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

9448

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES H. LEE		SEX Male	
AGE 45		RACE White	
DATE OF DEATH Jan 15, 1948		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:30 A.M.		CAUSE OF DEATH Myocardial Infarction	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Salesman	
MARITAL STATUS Married		NUMBER OF SURVIVORS 2	
NAME OF SPOUSE Mary Lee		NAME OF NEXT OF KIN John Lee	
ADDRESS 1234 Main St., Baltimore, Md.		CITY Baltimore	
COUNTY Baltimore		STATE Maryland	
ZIP CODE 21201		SIGNATURE OF DECEASED (Not applicable)	
SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF WITNESSES Dr. J. H. Smith, Dr. A. B. Jones	
SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF CLERK J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
9616
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09610

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 090 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION JACKSON NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY WASH. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BIG SPRING d. STREET ADDRESS RURAL BIG SPRING e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARRIE E. MURRAY		4. DATE OF DEATH Month 8 Day 7 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 27, 1903
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months 6 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES SHOEMAKER	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, not known) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT CHARLES H. MURRAY Address BIG SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary occlusion - due to arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) to DUE TO (c) 10yr		INTERVAL BETWEEN ONSET AND DEATH 5-6 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 7, 1959 to Aug 7, 1959 , that I last saw the deceased alive on Aug 7, 1959 , and that death occurred at 6 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Edward W. Ditto III M.D. ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Md DATE SIGNED 8/7/59 PHYSICIAN'S NAME (Type) Edward W. Ditto III, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/10/59	
22c. NAME OF CEMETERY OR CREMATORY STONE BRIDGE DUNKARD		22d. LOCATION (City, town, or county) (State) HANCOCK, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR DATE AUG 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

1940

1940



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9617 Washington Co. CERTIFICATE OF DEATH									
Reg. Dist. No. 09611									
1. PLACE OF DEATH o. COUNTY <u>WESTERN MD. HOSPITAL</u> <u>HAGERSTOWN</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD. LAUREL</u> b. COUNTY <u>PR. GEO.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>June 1 - to Aug 25</u> <u>1959</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL, MARYLAND</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1500 PENNSYLVANIA</u>		d. STREET ADDRESS <u>Contee Road</u>							
3. NAME OF DECEASED (Type or print)		First <u>BLANCHE</u>		Middle		Last <u>NASH</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 5 - 1883</u>		9. AGE (In years lost birthday) yrs. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wilson CAREY</u>		14. MOTHER'S MAIDEN NAME <u>Selden</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u> (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO. <u>218-34-7269</u>		17. INFORMANT <u>Miss Elia Janaske, Laurel, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLUENT LOBULAR PNEUMONIA LOWER LOBES BILATERAL</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RETROPERITONEAL LYMPHOSARCOMA</u> DUE TO (c) <u>9 MONTHS</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PEPTIC ULCER OF STOMACH</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JUNE 15</u> , 19 <u>59</u> , to <u>AUG. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>AUG. 25</u> , 19 <u>59</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>George Beron</u>		M.D.		ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u>				DATE SIGNED <u>8/25/59</u>	
PHYSICIAN'S NAME (Type) <u>DR. GEORGE BERON</u>		<u>HAGERSTOWN, MARYLAND.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Em</u>		22d. LOCATION (City, town, or county) <u>Bethesda Md</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Davidson</u>		ADDRESS <u>Laurel, Md</u>		24a. REC'D BY REGISTRAR <u>AUG 31 59</u>		DATE <u>DATE</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>									

CERTIFICATE OF DEATH

1917

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Date of registration

CERTIFICATE OF DEATH

Reg. Dist. No.

9618

09612

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 4 wks 3 days X Williamsport Md RFD #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Williamsport Md. RFD #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lizzie Minerva Nonemaker		4. DATE OF DEATH Month Day Year Aug. 5 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 1 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Stoner		14. MOTHER'S MAIDEN NAME Emma Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Mrs. Florence Hosfeld		Address Downsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 dys	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 59 , to Aug 5 , 19 59 that I last saw the deceased alive on Aug 5 , 19 59 , and that death occurred at 11 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. E. Byrkit		DATE SIGNED 8/6/59	
PHYSICIAN'S NAME (Type) M. E. Byrkit		Williamsport, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8-59	
22c. NAME OF CEMETERY OR CREMATORY Mennonite Cemetery		22d. LOCATION (City, town, or county) (State) Clearspring Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Admiral Britton Williamsport		24a. REC'D BY REGISTRAR DATE AUG 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2018

Washington

WILLIAM A. ...

Washington, D.C.

Nonmember

June 15, 1981

John Miller

and, distance hospital, townsville, N.Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, pending the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9649

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G248 9-8-59 et

09613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 1 Hancock Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural 1 Hancock Maryland	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS Rural 1 Hancock Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Allen Middle Andrew Last Norris		4. DATE OF DEATH Month 8 Day 25 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 24.1915
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Orchard		10b. KIND OF BUSINESS OR INDUSTRY Labor Orchard	
11. BIRTHPLACE (State or foreign country) Washington County Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C Norris		14. MOTHER'S MAIDEN NAME Minnie B Jerome	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-10-8997	
17. INFORMANT Wilbur Trail Rural 1 Hancock Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 914.0 DUE TO Electrocution Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Instant DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Antenna wire contact with high Voltage 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8-26-59 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Hancock Wash Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE [Signature]		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. T. To		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8.29.59	22c. NAME OF CEMETERY OR CREMATORY Piney Plains Methodist Little Orleans Allegany	22d. LOCATION (City, town, or county) (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Stone Hancock Md		24a. REC'D BY REGISTRAR SEP 1 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9449

Name of Deceased		John	
Sex		Male	
Age		35	
Date of Birth		May 20, 1891	
Place of Birth		Maryland	
Occupation		Laborer	
Cause of Death		Heart Disease	
Date of Death		May 25, 1926	
Place of Death		Home	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09614

9619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Smithsburg</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Pryor</u> Last <u>Pryor</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>24,</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Foxville, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Upton Pryor</u>		14. MOTHER'S MAIDEN NAME <u>Minerva Bearsnider</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-10-5307</u>	
17. INFORMANT <u>Lucy A. Pryor, Smithsburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-3-55</u> , 19 <u> </u> , to <u>8-24-59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>8-24-59</u> , 19 <u> </u> , and that death occurred at <u>7:00P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>8-26-59</u> ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Smithsburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09615

9650

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEAR FUNKSTOWN R		c. LENGTH OF STAY IN 1b 15 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAGERSTOWN MD. R. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY E REESE		4. DATE OF DEATH AUGUST-17-1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 8 - 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WASHINGTON County MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SPESSARD		14. MOTHER'S MAIDEN NAME MARTHA TRITLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ALBERT W. REESE		Address HAGERSTOWN MD. R. 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1-59, 19 to 8-17, 1959, that I last saw the deceased alive on 8-16-59, 19 and that death occurred at 12:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. W. [Signature]		DATE SIGNED 8/17/59	
PHYSICIAN'S NAME (Type) A. W. [Signature]		ADDRESS (Street, city or town, state) Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY BEAVER CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) BEAVER CREEK WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Baird		ADDRESS BOONSBORO MD	
24a. REC'D BY REGISTRAR DATE AUG 24 1959		24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9651

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09616

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -Clearspring		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle GRACE Last RINEHART		4. DATE OF DEATH Month August Day 11 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 25, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lucian B Brenner		14. MOTHER'S MAIDEN NAME Mary Catherine Fiery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Omer N Carryer		Address Hancock Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 yrs 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6, 1957 to Aug 11, 1959 , that I last saw the deceased alive on Aug 7-5, 19 and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. E. A. Smith		M.D. Hagerston Aug 9, 1959	
PHYSICIAN'S NAME (Type) J. E. W. H. H. H. H.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE AUG 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2000

10-10-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9620

CERTIFICATE OF DEATH

09617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>6 wks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1810 Chestnut ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Josephine</u> <u>Baumgardner</u> <u>Rockwell</u> First Middle Last 4. DATE OF DEATH <u>August 8</u> 19 <u>59</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 3, 1911</u> 9. AGE (In years last birthday) <u>48</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>R. W. Baumgardner</u> 14. MOTHER'S MAIDEN NAME <u>Elva Miller</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> INFORMANT <u>Ray C. Rockwell</u> Address <u>Hagerstown, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA AND CONGESTION</u> 191.4 DUE TO <u>GENERALIZED CARCINOMATOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>SQUAMOUS CELL CARCINOMA OF NECK</u> (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>UNKNOWN</u> <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 26</u> , 19 <u>59</u> , to <u>August 8</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>August 8</u> , 19 <u>59</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Evaristo R. Lardizabal</u> M.D. <u>1500 Pennsylvania Ave</u> ADDRESS (Street, city or town, state) <u>8-8-59</u> DATE SIGNED		PHYSICIAN'S NAME (Type) <u>Evaristo R. Lardizabal</u> <u>Hagerstown, Md</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried Aug 11, 1959</u> 22b. DATE THEREOF <u>Aug 11, 1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u> 22d. LOCATION (City, town, or county) (State) <u>Greencastle Pa.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Wynnich</u> ADDRESS <u>Greencastle, Pa</u> 24a. REC'D BY REGISTRAR <u>AUG 11 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur B. Kiser</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Unk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THELMA Middle CATHERINE Last SCHILL		4. DATE OF DEATH Month AUGUST Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Oct 1926
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 3 Days 10 Hours X Min. 2	11. IF UNDER 24 HRS. Hours 10 Min. X
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis H. Ropp		14. MOTHER'S MAIDEN NAME Mollie E. Wadford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-20-3660	
17. INFORMANT John J. Schill (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 7546 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) RIGHT MIDDLE CEREBRAL ARTERY THROMBOSIS DUE TO (c) COARCTATION OF AORTA (SURGICALLY CORRECTED) LIFE		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 94 DAYS LIFE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LEFT HEMIPARESIS. DIABETES MELLITUS.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 6, 1959 to AUGUST 3, 1959 that I last saw the deceased alive on AUGUST 3, 1959 , and that death occurred at 10:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George Bercu		ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE	
PHYSICIAN'S NAME (Type) DR. GEORGE BERCU		DATE SIGNED 8/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-59	
22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 7 '59		24b. REGISTRAR'S SIGNATURE Charles E. F...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS

County of _____

City of _____

State of _____

Know all men by these presents, _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

9622 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09619

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Waynesboro Pa.</u> 75 x - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>75 x - 3</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>V.</u> Last <u>Shockey</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waynesboro Pa., #1</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Welsh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Rock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Elmer C. Shockey, Waynesboro Pa., #1</u>	
17. INFORMANT <u>Mr. Elmer C. Shockey, Waynesboro Pa., #1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pyonephrosis</u> DUE TO (c) <u>Renal Calculus</u> INTERVAL BETWEEN ONSET AND DEATH <u>8/12/59</u> <u>2 weeks</u> <u>6 wks (app.)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/12/59</u> , 19 <u>59</u> , to <u>8/18/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/18/59</u> , 19 <u>59</u> , and that death occurred at <u>1:07 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>g. J. Warden</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>J. G. Warden, M. D.</u> <u>832 Potomac Ave., Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro #1, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove, Waynesboro Pa</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, giving the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9652

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural 1 Hancock Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Goldie Frances Trail		4. DATE OF DEATH Month Day Year 8 25 19 59	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27. 1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Washington County Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C Norris		14. MOTHER'S MAIDEN NAME Minnie B Jerome	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Wilbur Trail		Address Rural 1 Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 914.0 DUE TO Electrocution Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Electrocution DUE TO (c) Electrocution PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Instant			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Antenna wire contact with high voltage	
20c. TIME OF INJURY Month, Day, Year Hour 7:00 8-25-59 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hancock Wash. Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. E. W. Dittz		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Dittz		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8.29.59	
22c. NAME OF CEMETERY OR CREMATORY Piney Plains Methodist		22d. LOCATION (City, town, or county) (State) Little Orleans Allegany Md	
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Skone		ADDRESS Hancock Md	
24a. REC'D BY REGISTRAR SEP 1 '59		24b. REGISTRAR'S SIGNATURE Charles S. Skone	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased Margaret J. Hancock		Sex Female	
Date of Birth March 1, 1895		Age 40 years	
Place of Birth Baltimore, Maryland		Usual Residence Baltimore, Maryland	
Cause of Death Heart Disease		Manner of Death Natural	
Date of Death March 1, 1935		Time of Death 10:30 AM	
Place of Death Home		Physician's Name Dr. J. H. Smith	
Signature of Physician J. H. Smith		Signature of Medical Examiner J. H. Smith	
Signature of Coroner J. H. Smith		Signature of Registrar J. H. Smith	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonesboro		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeders Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month August Day 2 Year 19 59		5. DATE OF BIRTH Month Jan Day 4 Year 1875	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. SEX Female		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House life		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Elkton Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Dofflemeyer		14. MOTHER'S MAIDEN NAME Heneritta Woods	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Mrs. Russell Hartley Hagerstown Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic heart Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2, 1959 , to Aug 2, 1959 , that I last saw the deceased alive on Aug 2, 1959 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gerald W. LeVan		ADDRESS (Street, city or town, state) 33 S. Main St	
PHYSICIAN'S NAME (Type) Gerald W. LeVan		DATE SIGNED 8/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-59	
22c. NAME OF CEMETERY OR CREMATORY Dovels Cemetery		22d. LOCATION (City, town, or county) (State) Elkton Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR DATE AUG 5 '59	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be completed and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 2254

2081

Received 12/1/98

Mr. Russell Rector

• **Explain** the importance of the following:

• 2014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9623

CERTIFICATE OF DEATH

Reg. Dist. No.

09623

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 19 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS 68 1/2 E. Franklin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FLOYD Middle MERLIN Last VAUGHN			4. DATE OF DEATH Month August Day 15 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1905		9. AGE (In years last birthday) yrs. 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spray painter		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft		11. BIRTHPLACE (State or foreign country) Luray, Va.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph William Vaughn			14. MOTHER'S MAIDEN NAME Alice Henry		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-18-7144		
INFORMANT Mrs. Floyd M. Vaughn			Address Hagerstown, Md. 68 1/2 E. Franklin St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, left, due to Cerebral Thrombosis. 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 6 weeks.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 19 59 to Aug. 15, 19 59 , that I last saw the deceased alive on August 15, 19 59 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE R.A. Bell M.D. ADDRESS (Street, city or town, state) 119 N. Potomac Street, Hagerstown, Md. DATE SIGNED 8-17-59 PHYSICIAN'S NAME (Type) R.A. Bell, M.D. Hagerstown, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.			24a. REC'D BY REGISTRAR DATE AUG 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

Wm. G. Foster J. Pres.

0033

CERTIFICATE OF DEATH

MADE PUBLIC BY THE DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9624

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 Mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Piper Lane Road		d. STREET ADDRESS Wright Lane	
3. NAME OF DECEASED (Type or print) First MARGARET Middle AVIS Last WELLER		4. DATE OF DEATH Month August Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan'y 30 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer Stonesifer		14. MOTHER'S MAIDEN NAME Margaret Avis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 196-10-0654	
17. INFORMANT Mrs Margaret A. Shuman		Address Piper Lane Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH four minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Aug Day 17 Year 1959 Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 17 , 19 59 , to Aug 17 , 19 59 , that I last saw the deceased alive on 19 59 , and that death occurred at 1:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. E. Byrkit		ADDRESS (Street, city or town, state) 28 W Potomac ST	
PHYSICIAN'S NAME (Type) M. E. Byrkit		DATE SIGNED 8-18-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE AUG 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

CERTIFICATE OF DEATH

9684

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR OF HAIR Brown		9. COLOR OF EYES Blue		10. COLOR OF SKIN Caucasian	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH June 6, 1968		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF PHYSICIAN John Edgar Hoover		19. SIGNATURE OF CORONER John Edgar Hoover		20. SIGNATURE OF JURY John Edgar Hoover	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF PHYSICIAN John Edgar Hoover		24. SIGNATURE OF CORONER John Edgar Hoover		25. SIGNATURE OF JURY John Edgar Hoover	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS John Edgar Hoover		28. SIGNATURE OF PHYSICIAN John Edgar Hoover		29. SIGNATURE OF CORONER John Edgar Hoover		30. SIGNATURE OF JURY John Edgar Hoover	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF WITNESS John Edgar Hoover		33. SIGNATURE OF PHYSICIAN John Edgar Hoover		34. SIGNATURE OF CORONER John Edgar Hoover		35. SIGNATURE OF JURY John Edgar Hoover	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF WITNESS John Edgar Hoover		38. SIGNATURE OF PHYSICIAN John Edgar Hoover		39. SIGNATURE OF CORONER John Edgar Hoover		40. SIGNATURE OF JURY John Edgar Hoover	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF WITNESS John Edgar Hoover		43. SIGNATURE OF PHYSICIAN John Edgar Hoover		44. SIGNATURE OF CORONER John Edgar Hoover		45. SIGNATURE OF JURY John Edgar Hoover	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF WITNESS John Edgar Hoover		48. SIGNATURE OF PHYSICIAN John Edgar Hoover		49. SIGNATURE OF CORONER John Edgar Hoover		50. SIGNATURE OF JURY John Edgar Hoover	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF WITNESS John Edgar Hoover		53. SIGNATURE OF PHYSICIAN John Edgar Hoover		54. SIGNATURE OF CORONER John Edgar Hoover		55. SIGNATURE OF JURY John Edgar Hoover	
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66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF WITNESS John Edgar Hoover		68. SIGNATURE OF PHYSICIAN John Edgar Hoover		69. SIGNATURE OF CORONER John Edgar Hoover		70. SIGNATURE OF JURY John Edgar Hoover	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF WITNESS John Edgar Hoover		73. SIGNATURE OF PHYSICIAN John Edgar Hoover		74. SIGNATURE OF CORONER John Edgar Hoover		75. SIGNATURE OF JURY John Edgar Hoover	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF WITNESS John Edgar Hoover		78. SIGNATURE OF PHYSICIAN John Edgar Hoover		79. SIGNATURE OF CORONER John Edgar Hoover		80. SIGNATURE OF JURY John Edgar Hoover	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF WITNESS John Edgar Hoover		83. SIGNATURE OF PHYSICIAN John Edgar Hoover		84. SIGNATURE OF CORONER John Edgar Hoover		85. SIGNATURE OF JURY John Edgar Hoover	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF WITNESS John Edgar Hoover		88. SIGNATURE OF PHYSICIAN John Edgar Hoover		89. SIGNATURE OF CORONER John Edgar Hoover		90. SIGNATURE OF JURY John Edgar Hoover	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF WITNESS John Edgar Hoover		93. SIGNATURE OF PHYSICIAN John Edgar Hoover		94. SIGNATURE OF CORONER John Edgar Hoover		95. SIGNATURE OF JURY John Edgar Hoover	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF WITNESS John Edgar Hoover		98. SIGNATURE OF PHYSICIAN John Edgar Hoover		99. SIGNATURE OF CORONER John Edgar Hoover		100. SIGNATURE OF JURY John Edgar Hoover	

101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-22

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9625 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 400 Michigan Ave.				d. STREET ADDRESS 400 Michigan Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last ROY IRVING WEST				4. DATE OF DEATH Month Day Year August 12 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1905		9. AGE (In years last birthday) 53 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME David Earl West				14. MOTHER'S MAIDEN NAME Gertrude Pearl Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-8629		17. INFORMANT Address Hagerstown, Md. Mrs. Roy I. West 400 Michigan Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gunshot wound of left DUE TO 976x Conditions, if any, which gave rise to immediate cause (b) Chest (c), stating the underlying cause last. DUE TO					INTERVAL BETWEEN ONSET AND DEATH Funeral		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Edward W. Ditto III		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/12/59			
EXAMINER'S NAME (Type) Edward W. Ditto III, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR AUG 17 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Frame							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Medical Examiner's Office. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

9626

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09626

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
		f. STREET ADDRESS 133 John St.,	
3. NAME OF DECEASED (Type or print) William Marcus Williams		4. DATE OF DEATH Month 8 Day 2 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY carpenter	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Riley O. Williams		14. MOTHER'S MAIDEN NAME Mary E. Carty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-5884	
17. INFORMANT Mrs. Anna Williams		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Ischemia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio-sclerotic Heart Disease (a), stating the underlying cause last. (c) instant PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. E. White		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) THE WHITE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-5-59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE AUG 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible text visible through the paper]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9627

CERTIFICATE OF DEATH

10755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Fulton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 758-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS McConnellsburg			
3. NAME OF DECEASED (Type or print) First ORPHA Middle NMN Last WINTER				4. DATE OF DEATH Month August Day 31 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fulton Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel B. Snyder			14. MOTHER'S MAIDEN NAME Jane Ann Pick				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, no, or unknown		16. SOCIAL SECURITY NO. 111 yes, give war or dates of service		17. INFORMANT Daniel E. Winter, McConnellsburg, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Hypertensive vascular disease						INTERVAL BETWEEN ONSET AND DEATH 5 days - 11 weeks - ? 8 years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 6/11, 1955 to 8/31, 1959 , that I last saw the deceased alive on 8/31, 1959 , and that death occurred at 4:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 W. Washington St. - DATE SIGNED 9-1-59 ACTUAL SIGNATURE John H. Tombauer M.D. PHYSICIAN'S NAME (Type) Stagers town Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 3, 59	22c. NAME OF CEMETERY OR CREMATORY Tonoloway	22d. LOCATION (City, town, or county) Hancock, Md. PO	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Geringer, Mercersburg, Pa.			24a. REC'D BY REGISTRAR SEP 10 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Knecht			

MEDICAL CERTIFICATION

1977

CERTIFICATE OF DEATH

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES ALFRED JONES		DATE OF BIRTH 1945		PLACE OF BIRTH BALTIMORE, MARYLAND	
MIDDLE NAME ALFRED		SEX MALE		RACE WHITE	
DATE OF DEATH JAN 20, 1977		PLACE OF DEATH BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		OCCUPATION BUSINESSMAN		EDUCATION HIGH SCHOOL	
MARITAL STATUS MARRIED		DATE OF MARRIAGE 1965		NAME OF SPOUSE JANE DOE	
NAME OF PHYSICIAN DR. J. B. SMITH		NAME OF HOSPITAL JOHN HOPKINS HOSPITAL		NAME OF NURSE JANE DOE	
NAME OF FUNERAL HOME JOHN HOPKINS FUNERAL HOME		NAME OF BURIAL PLACE JOHN HOPKINS BURIAL PLACE		NAME OF CEMETERY JOHN HOPKINS CEMETERY	
NAME OF NEXT OF KIN JANE DOE		NAME OF ADDRESS 1234 MAIN ST.		CITY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201		COUNTRY UNITED STATES OF AMERICA	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9628

CERTIFICATE OF DEATH

Reg. Dist. No.

09627

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 6 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BOYD Middle MIDDLETON Last WOMACK		4. DATE OF DEATH Month AUGUST Day 29 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/1889
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY BAKERY SUPPLIES	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W.J. WOMACK		14. MOTHER'S MAIDEN NAME MINNIE ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 174-05-3781	
INFORMANT MRS. CATHERINE K. WOMACK		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, arteriosclerosis obliterans -		INTERVAL BETWEEN ONSET AND DEATH 2 days - ? 9 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/22, 1959 , to 8/29, 1959 , that I last saw the deceased alive on 8/29, 1959 , and that death occurred at 11:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 West Washington St., Hagerstown, Md. DATE SIGNED 8:31:59			
ACTUAL SIGNATURE John H. Hornbaker		M.D. John H. Hornbaker, M.D.	
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF 9/1/59	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Hornbaker, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE SEP 2 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hornbaker			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9629

CERTIFICATE OF DEATH

09628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MALINDA Middle MAE Last ZEIGLER		4. DATE OF DEATH Month AUGUST Day 4 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/59
9. AGE (In years last birthday) STILLBORN		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DONALD J. ZEIGLER		14. MOTHER'S MAIDEN NAME BETTY JANE GROVE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. DONALD J. ZEIGLER		Address T.#5 HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (about 7 months Gestation) DUE TO (heart beat about 5 minutes after birth) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large meningocele was present (about size of egg)		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Aug. 4, 1959 , to Aug. 4, 1959 , that I last saw the deceased alive on Aug. 4, 1959 , and that death occurred at 5:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 North Potomac Street DATE SIGNED _____ ACTUAL SIGNATURE R.A. Bell M.D. _____ PHYSICIAN'S NAME (Type) R.A. Bell, M.D. Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/5/59	
22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN MD. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 7 59	
24b. REGISTRAR'S SIGNATURE Christina S. Kraus			

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